



## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment, directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have had the opportunity to review your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Middletown Vein and Aesthetic Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Middletown Vein and Aesthetic Center and Radiologic Associates of Middletown at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed in order to carry out treatment, payment, or health care operations.

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_