



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & 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
- Follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received InterMed’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that InterMed has the right to change its Notice of Privacy Practices from time to time and that I may contact InterMed 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 to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ DOB: _____

Signature _____

Relationship to Patient _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: