



**Janette A. Williams**

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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

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

I have received, read and understand your *Notice of Privacy Practices* containing a more completed description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above 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 (print) \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE USE ONLY**

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

Date	Initials	Reason
_____	_____	_____