NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

AMANDEEP PAL M.D. PLLC

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABLIITY AND 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:

- CONDUCT, PLAN AND DIRECT MY TREATMENT AND 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 CERTIFCATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR **NOTICE OF PRIVACY PRACTICES** CONTAINING A MORE COMPLETE 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 ORGANIZTION AT ANY TIME AT THE ADDRESS LISTED 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 HEALTHCARE 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 _____

RELATIONSHIP TO PATIENT _____

SIGNATURE_____

DATE_____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENTS SIGNATURE IN ACKNOWLEDGEMENT ON THE NOTICE OF PRIVACE PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO SO – DOCUMENTED BELOW

DATE_____TIME_____
REASON_____