Center Medicine

Written HIPAA Privacy Practices Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ (Please print patient name) have received a copy of the Medical Practice's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature_____
Date_____
Authorized Representative of Patient_____
Relationship to Patient_____
Date_____