

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

## RICARDO BERNAL, MD

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:

- 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 physician certifications.

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 organization at any time at the address above to obtain a current copy of the **Notice of Private Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree the you are bound to abide by such restrictions.

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

**Relationship to Patient:** \_\_\_\_\_

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

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

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### 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:	Reasons:
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