MICHAEL A. STEIN, D.P.M.
Gentle Compassionate Foot Care

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health 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 in-directly. 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 the 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do, 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 this Notice of Privacy Practices acknowledgement, but was unable to do so as documented bellow:

_____

_____

Date: _____ Initials: _____