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**Acknowledgement of Receipt of HIPAA & Notice of Privacy Practices for Protective Healthcare Information**

**Our Privacy Pledge**

 (business name) is very concerned with protecting your privacy and maintaining your trust in confidence as a valued patient of this office. This form hereby acknowledges that I (print name) on behalf of myself and/or my minor child/ward as a patient(s) of (business name) had/have been given a copy or adequate opportunity to review a copy of the (business name) HIPAA and *Notice of Privacy Practices for protective healthcare* information. I understand that this notice explains the use and disclosure of my healthcare information; including the circumstances of which (business name) may use or disclose my healthcare information. I understand that I have been given the opportunity to discuss any of my concerns and questions about this notice and privacy of my healthcare information.

**Changes to Privacy Practice**

I specifically acknowledge and understand that (business name) has the right to change its privacy practices as described in that notice. If any such change is made to the privacy practices, I understand that (business name) will notify me, in writing, of such changes upon my consultation at the office for treatment or by mail should I continue to be an active patient of this office.

**Right to Limit Uses or Disclosures**

I understand that I have the right to request that (business name) does not disclosure health information to specific individuals, companies, or organizations. I understand that I must notify (business name) , in writing, of any restrictions on the use or disclosure of my health information. I understand that (business name) is not obligated to agree to such restrictions and will subsequently provide me of notice should that situation develop. However, if no objection is raised to such restrictions, I understand that the restriction(s) shall be binding upon (business name) .

**Right to Revoke Authorization**

I understand that I may revoke any of the authorization(s) given to (business name) at any time; however I understand that such revocations must be in writing. I understand that (business name) will not be able to honor any revocation request if they have already released my health information before receiving such request to revoke the authorization. I understand that an insurance company may have a right to my health information if they should decide to contest any of the claims submitted by my healthcare provider and that I may be required to give authorization as a condition of obtaining such insurance coverage.

Signature of Patient/Parent/Legal Guardian Date

Printed Name of Patient if Minor/Ward

\***Important**: This information should be obtained from patient at time of initial visit. Office should also send a separate letter to any legal representative using a form similar to that present in other resources available at this website or by contacting the author of this document.