FAMILY MEDICINE NYC, P.C.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

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 or indirectly.

- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessment. and physician certifications.

I hereby received, read and understand your Notice of Privacy Practices containing more complete description of the uses disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time the address above to obtain a current copy of the Notice of Privacy Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care 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.

Further, I give permission to the doctors and/or their authorized representative at **Family Medicine NYC P.C**, to communicate test results and other private medical information to me via the following:

Yes or No: Secure Phone Number/Voicemail (_____) _____-_____

Yes or No: Secure Email _____

Print Patient Name: _____

Relationship to Patient: Self or Guardian

Signature: _____

Date: _____/_____/_____