HIPAA – Patient Acknowledgment Form

Our Notice of Privacy Practices (NPP) provides information about how **Dr. Christopher Kowalski** may use and disclose protected health information (PHI) about you. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

I give permission for **Dr. Christopher Kowalski** to:

____ Leave a message regarding an appointment at_____(phone number)

____ Leave a message regarding test results _____ (phone number)

_____ Share medical information with:

(1) Name_____ Relationship_____

Phone_____

(2) Name_____ Relationship_____

Phone _____

I assume responsibility to inform the practice of any changes in the above information.

Print Patient's Name	Date
Patient's Date of Birth	Relationship to Patient
Signature	Today's Date

____ I have received the Notice of Privacy Practices

Signature_____

Relationship to patient_____Date_____

January 5, 2015