HIPAA – PATIENT ACKNOWLEDGEMENT 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 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 options. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare options.

I give permission for Dr. Christopher Kowalski to:

_____ Leave a message regarding an appointment at **Phone#**:_____

_____ Leave a message regarding test results at **Phone#**:_____

_____ 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 Name**:_____

- **Patients DOB**:_____ **Relationship to Patient**:_____

- **Signature**:_____ **Date**:_____

_____ *I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES*

SIGNATURE:_____ **DATE**:_____