RECEIPT AND ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices of the medical office of Dr. Lauren O'Sullivan D.O., LLC.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certification

I understand that the Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information, and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative* Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Office Use Only

❑ Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date