POCATELLO ORTHOPAEDICS & SPORTS MEDICINE INSTITUTE, PA

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 (PHI). 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, whether directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.

I understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Pocatello Orthopaedics & Sports Medicine Institute, P.A. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time at the address above to obtain a current copy of the *Notice.*

I acknowledge that a copy of the Notice of Privacy Practices has been offered to me. I understand that I may request in writing that you restrict how my private information may be used or disclosed to carry out Treatment, Payment or Health Care Operations. I also understand that you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (PRINT)_____

Relationship to Patient _____

Signature _____

Date _____

***A COPY OF THE NOTICE OF PRIVACY PRACTICES IS AVAILABLE FOR YOUR PERSONAL USE UPON REQUEST