NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment.

I hereby acknowledge that I have been presented with a copy of Dr. Chavez's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

I give my permission to disclose and release my protected health information to the individuals listed below. This health information may be used to enable the person(s) I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons. This authorization shall remain in effect until otherwise notified. This authorization can be revoked in writing at any time by notifying our office.

Patient Signature: X _____ Date: _____

Patient Name: _____ DOB: _____

Name(s):	Relationship:	Phone:
_____	_____	_____
_____	_____	_____

O **At this time I do NOT give my permission to release my PHI to anyone but myself and my doctor (s).**

Office use:

I have attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: _____ Staff Member: _____ Date: _____

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