

Consent Expiration Date (if any): _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
Vital Allergy & Asthma Center

I understand that, under the Health Insurance Portability & 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 provider 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 certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____