<INSTRUCTIONS. TO USE THIS DOC, CLICK ON FILE->MAKE A COPY, SAVE IT TO YOUR DRIVE>

LOGO HERE	HEALTHCARE ORGANIZATION NAME ADDRESS

Notice of Privacy Practices

Effective Date: <enter your practice's effective date here>
Practice contact: <enter your privacy contact person's name and number here>

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**.
We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy of privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.
If you have any questions about this Notice, please call us at the number listed above.

Acknowledgement of Receipt of Notice of Privacy Practices:
I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Name of patient: Date of birth Signature (above) Address: Date:	If not signed by the patient, please indicate the relationship: __ Parent or guardian of minor patient __Guardian or conservator of an incompetent patient

ADD CONTACT INFORMATION HERE <PHONE, FAX, WEB, EMAIL ETC>