

Peter A. Linfoot, Ph.D., M.D., Inc.

HIPPA: Acknowledgement of use and disclosure of Health Information

Please complete the following information:

Patient Name: _____

Patient Address: _____

Patient Telephone: _____ Date of Birth: _____

Please read the following statements carefully:

Purpose of this form: HIPAA regulations require that every patient have a completed and signed Acknowledgement in the patient chart. This form acknowledges you have been given the opportunity to read our Notice of Privacy Practices. This form must be completed only once while you are a patient at Peter A. Linfoot, Ph.D., M.D., Inc.

Notice of Privacy Practices: You may read our Notice of Privacy Practices before you sign this form. Our notice provides a description of our treatment, payment activities and healthcare operations; of the uses and disclosures we may make of your protected health information; and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in your Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our Privacy officer at (925) 355-3250. **Please sign your acknowledgement.**

I, _____, have had the opportunity to read and consider the contents of this form and your Notice of Privacy Practices.

If this acknowledgement form is signed by a parent or patient representative, please complete the following:

Parent or Patient Representative Name: _____

Relationship to the Patient: _____

Signature _____ Date: _____

You are entitled to a copy of this acknowledgement form after you sign it.