ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTICE TO PATIENT

Under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), you have certain rights to privacy regarding your protected health information (PHI), and Restorative Therapies is required to provide you with a current copy of our *Notice of Privacy Practices.* The notice explains how Restorative Therapies may use and/or disclose your health information. Restorative Therapies cannot discuss PHI with anyone other than the patient (or parent of a minor child and/or legally appointed guardian/ representative) unless authorized to do so.

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Phone #: _____ **Email:** _____

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been provided with a current copy of the *Notice of Privacy Practices*. I understand that a current copy of the *Notice of Privacy Practices* may be accessed any time on the Restorative Therapies website (https://restorative-therapies.com/privacy-policy/), and I may request a paper or electronic copy by contacting the Health Information Management department.

Signature of Patient or Representative*: _____ **Date:** _____

Name of Representative: _____ Relationship to Patient: _____

**** If not signed by the patient or parent of a minor child, authorizing documentation is required.***

(e.g. Power of Attorney or Legal Guardianship)