

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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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 & follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and clinician certifications.

I have received, read, and understand 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* form 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 restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

OFFICE USE ONLY

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

Date	Initials	Reason