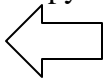


# PRIVACY NOTICE ACKNOWLEDGEMENT

It is of the utmost importance that we protect your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient.

If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be more than happy to address them.

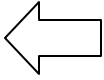
I acknowledge that I have been made aware of and offered a copy of the Notice of Privacy Practices for Protected Health Information. \_\_\_\_\_  **(Please Initial)**

## APPOINTMENT REMINDER HEALTH CARE INFORMATION AUTHORIZATION

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders and/or information either by phone, mail or electronic mail.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone that has access to the reminder of information by anyone that has access to the reminder or information and may no longer be protected by the federal privacy laws.

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization at any time; however, the revocation must be in writing and will become effective once received. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I authorize the use and/or disclosure of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office. \_\_\_\_\_  **(Please initial)**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_