**Patient Acknowledgement and Receipt of**

**Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information**

Name:Click here to enter patient name.

The undersigned does hereby acknowledge that he or she has received a copy of this office’s Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office’s HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Noti**c**e of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this Click here to enter a date.

By Click here to enter signature.

Patient’s Signature

If patient is a minor or under a guardianship order as defined by State law:

By Click here to enter signature.

Signature of Parent Guardian