

Dr. Aaron Gross
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your **Notice of Privacy Practices** containing a more complete descriptor, of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact the 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 and disclosed to carry out treatment, payment of health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide to 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:
