ANNITA JOHN, MDPC

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Acknowledgement of Receipt of Privacy Notice

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 this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among 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 physicians certifications.
- I acknowledge I have received your Privacy Notice containing a more complete description of the uses and disclosures of my health information.
- I understand I may request in writing that you restrict how my private information is used or disclosed to carry cut treatment, payment, or healthcare operations.

Patient/Guardian or Personal Representative Signature/Date:

_____

Patient authorizes the release of information to the following family members or friends, please list the name of the person as well as the phone number where they can be reached:

_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____