

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Interactive Health Concepts, Inc.
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Patients Name _____ Date of Birth _____

I understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practice.

The practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

Signature: _____

Relationship: _____

Date: _____