Noam Koenigsberg, MD • 960 West 41st Street Suite 410 • Miami Beach, 33140 • 305-985-2161

Notice of Privacy Practices Acknowledgement

Client's Name:_____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up with the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers such as credit card companies.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that Dr. Koenigsberg restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Dr. Koenigsberg is not required to agree to my requested restrictions and, but if Dr. Koenigsberg does then he is bound to abide by such restrictions. If Dr. Koenigsberg and myself cannot agree to my restrictions then we can discuss further options, which will most likely include a referral to another doctor for continued care.

I understand that I may revoke this consent in writing at any time, except to the extent that Dr. Koenigsberg has taken action relying on this consent.

Client's Signature:_____

Date Signed:_____