Notice of Privacy Practices
Acknowledgement of Receipt

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 and will be used to:

- Provide treatment and services
- Bill and conduct payment from myself, my insurance provider, or a third party payer
- Conduct healthcare operations, such as assess my care and outcomes and quality assessments

By signing below, I am acknowledging the following:

- I have received a copy of the Notice of Privacy Practices from Budding Voices containing a complete description of my rights and the uses and disclosures of my health information.
- I have read and understand the Notice of Privacy Practices.
- I understand that the Notice of Privacy Practices is located on the organization's premises, attached to this document, and on the organization's website.
- I understand that Budding Voices has the right to change its Notice of Privacy Practices at any time.
- I understand that I may contact the company at any time to obtain a current paper copy of the Notice of Privacy Practices.
- I understand that I may request in writing that this organization restrict how my private information is used or disclosed.
- I understand that this organization is not required to agree to my requested restrictions.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

For Office Use Only

Complete this section if this form is not signed and dated by the patient or the patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Notice of Privacy Practices but was unable to for the following reason:

☐ patient refused to sign ☐ patient unable to sign ☐ other _____

Employee Name: _____ Date: _____

Signature: _____