Himanshu P. Parikh, M.D.

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and 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: plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from designated third-party payers, conduct normal health-care operations such as quality assessments or evaluations, and physician certifications.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print). I have reviewed such Notice of Privacy Practices prior to signing this consent. I understand that this office has the right to change its Notice of Privacy Practices time to time, and that I may contact this office at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment, or health-care operations. I also understand the office is not required to agree to my requested restrictions, but if the office does agree, then it is to abide by such restrictions. I understand that I may revoke this consent in writing anytime, except to the extent that the office has acted relying on the consent.

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

Patient Name ____

Address ____

I have received a copy of the Notice of Privacy Practices.

Signature ____________________________________ Date ________________________

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:___________________
  ____
- ☐ Other ____

Prepared by ____

Signature _________________________________ Date ____________________________