NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I have been provided with REHABVISIONS Notice of Privacy Practices that describes how my health information is used and shared.

I understand that REHABVISIONS reserves the right to change this notice at any time. I may obtain a current copy by contacting the clinic or the billing office. For appointment reminders, healthcare treatment options, billing concerns or other health services that may be of interest to me, REHABVISIONS may contact me as noted below:

RehabVisions may contact me at home: ❍Yes ❍No

- Home Phone: ( ) _____-_____
- OK to leave a message? ❍Yes ❍No

RehabVisions may contact me at work: ❍Yes ❍No

- Work Phone: ( ) _____-_____
- OK to leave a message? ❍Yes ❍No

RehabVisions may contact me on my cell phone: ❍Yes ❍No

- Cell Phone: ( ) _____-_____
- OK to leave a message? ❍Yes ❍No

This authorization will remain in effect until revoked in writing. Copies of my chart or any other written information are not covered by this authorization.

_____ _____

Patient Name *(Please print)* **Date**

_____ _____

Signature **Relation** *(self, parent, guardian, etc*