NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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1033 Clifton Avenue
Clifton, New Jersey 07013

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:

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

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and/or health care operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient
Name:_____ Date:_____

Patient Signature:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE:_____ INITIALS:_____ REASON:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Thomas Graziano, DPM and/or his staff to disclose my health information. I understand that all this authorization is voluntary and I have personally designated the individual named to receive this information.

_____
Signed

_____
Designee Relationship to Patient