Cincinnati Dermatology Center
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This office has always made it a policy to protect your privacy however the federal government now requires that we notify our patients of this fact and have a patient or guardian sign an acknowledgement to be kept as a permanent part of the medical record stating that this notification has been given. The complete Privacy Practice Notice for this office is on display in the waiting room or a copy can be given to you to read at your convenience.

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 among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' 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 this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address below 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 or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:____

Relationship to Patient:____

Signature:____

Account Number:____

May Release Info To:_______________________________________