

# Houston Family Practice

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## Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and 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 treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 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 or health care operations. I also understand you are not required to agree to my request restriction, but if you do agree, then you are bound to abide by such restrictions.

(Print)

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship

To Patient:      Self      Parent      Legal Guardian

If patient is a minor:

Parent or Guardian PRINT NAME: \_\_\_\_\_