HIPAA

PATIENT NAME_____ **DOB** _____/_____/_____
(Please Print)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used for: **treatment, payment, and healthcare operations.** NMHC'S NOTICE of PRIVACY PRACTICES is posted in each clinic reception area, is available from any front desk associate, and can be viewed online at nemohealthcouncil.com. I understand Northeast Missouri Health Council, Inc. (NMHC, Inc.) has the right to change its Notice of Privacy Practices from time to time. My signature below indicates I have read and understand NMHC's Notice of Privacy Practices.

Patient/Guardian Signature_____ **Date** _____/_____/_____