NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

FACILITY NAME: VALLEY INTERNAL MEDICINE AND PEDIATRICS
ADDRESS: 10900 N. SCOTTSDALE RD. #206, SCOTTSDALE, AZ 85254

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 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 understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this facility has the right to change its Notice of Privacy Practices from time to time and that I may contact the facility 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 healthcare options. I also understand that you are not required to agree to my restricted restrictions; but if you do agree, then you are bound to abide by these restrictions.

PATIENT'S NAME: ______________________________

RELATIONSHIP TO PATIENT: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

Office Use Only

I attempted to obtain the patient's signature on the Notice of Privacy Practices form, but was unable to do so as documented below:

Date: ____________ Name: ______________________________

Reason: ______________________________

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