



Owned and Operated by Speech-Language Pathologists
(703) 821-1363

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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:

- Provide treatment and services
- Bill and collect payments from you or a third-party payer
- Conduct healthcare operations such as assess my care and outcomes and quality assessments

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

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree then it is bound to abide by such restrictions.

Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____