PREMIER FAMILY MEDICAL, PC

73 Bloomfield Avenue, Caldwell, New Jersey 07006
Tel: 973-403-3200 Fax: 973-403-3250

VITO MAZZOCCOLI, MD
Medical Director

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

MAY LEAVE MESSAGES ON ANSWERING MACHINE?

Yes______ No______ Yes, but____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right 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 physicians certifications.

I acknowledge that I have received your *Notice of Private Practices* containing a more complete description of the uses and disclosure 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

ADULT

I am a patient of Premier Family Medical and I hereby acknowledge receipt of Premier Family Medical's Notice of Privacy Practices.

Print Name:______________________________________

Signature:____

Date:____

MINOR

I am a parent or legal guardian of:_________________________________
print patient's name
and I hereby acknowledge receipt of Premier Family Medical's Notice of Privacy Practices.

Print Name:____

Relationship to patient: □ Parent □ Legal Guardian

Signature:____

Date:____

OFFICE USE ONLY

I attempted to obtain the patient signature in acknowledgment of this Notice of Private Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:
_____/_____/_____		