THE CENTER FOR BALANCE and dizziness
PHYSICAL THERAPY

HIPPA ACKNOWLEDGMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize The Center for Balance to use and disclose my protected health information to carry out treatment, obtaining payments from third-party payers, and or day-to-day Healthcare operations of this practice.

I have also been informed and given the right to review and secure a copy of my notice of Privacy Practice which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payments, and Healthcare operations. I understand that I may rework this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Notice of Privacy Practices Acknowledgement Form

The notice of privacy practice describes how medical information about you may be used and disclosed and how you can get access to this information. please **review it carefully,** as **it explains**

- How this office will use and disclose your protected health information.
- Your privacy rights with regard to your protected health information.
- This office's obligations concerning the use and disclosure of your protected health information.

I acknowledge that I have received a copy of the office notice of privacy practices. I further acknowledge that the office notice of privacy practices is available at the front desk open request.

Patient Signature: _____ Date:_____