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Patient Acknowledgement of Receipt of Privacy Notice

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 for:

- TREATMENT: Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- PAYMENT: Obtain payment on my behalf, as requested by me, from third-party payers.
- OPERATIONS: Conduct normal healthcare operations, such as consultations with and reports to other professionals as requested and with written authorization.

I acknowledge that I have received Dr. Munschauer's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Dr. Munschauer has the right to change the Notice of Privacy Practices from time to time and that I may contact her at any time at the address above to obtain a current copy.

Print Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________