V. LIGHTNER FAMILY DERMATOLOGY
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:

- 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 for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices of Virginia Lightner Family Dermatology that contains a more complete description of the uses and disclosures 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 Private Practices.

I understand that I may request in writing, by filling out a Restriction of Health Information Request Form, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Sharing Information with Family and/or Friends

I understand that, unless I provide detailed instructions below, limited personal health information may be shared with family, friends and/or representatives: (1) if related to my care or payment for my care, or (2) if needed to notify individuals about my location or condition. Please indicate whether you permit your personal health information to be shared by checking below:

____ If necessary, it is OK if my personal health information is shared with family, friends and representatives.

____ I do NOT want my personal health information shared with family, friends, and/or representatives.

Patient Name: _____

Relationship to Patient: _____
indicate self, parent, legal guardian, POA or other (other must specify)

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: