721 Snelling Avenue South
St. Paul, MN 55116
651-690-1311

Notice Of Privacy Practices Acknowledgement

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 my be involved in that treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that Parkway Family Physicians has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact Parkway Family Physicians 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 request restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: ______________________ Date Of Birth: _________
Relationship To Patient: _________________________
Signature: ______________________ Date: _________

Office Use Only

Patient #: _________________. Check here if this was recorded in the computer ____.

I attempted to obtain the patient's signature in acknowledgement of this Notice of privacy Practices Acknowledgement, but was unable to do so as documented below:
Date: ___________
Initials: ___________
Reason: ____
____

Clinic Hours: Monday – Friday 9:00 AM – 5:00 PM