**Isaacs & Associates**

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ACKNOWLEDGEMENT

RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge the receipt of Isaacs & Associates Notice of Privacy Practices which provides me with detailed information about how Isaacs & Associates may use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

I also understand that if Isaacs & Associates amends its Notice of Privacy Practices, I will be informed of the change and may obtain a copy of the revised Notice by contacting th office for a copy at 508-668-3284.

I have the right to request, in writing, that Isaacs & Associates restricts how it uses an discloses my protected health information for the purposes of treatment, payment, or health care operations. I acknowledge that Isaacs & Associates is not required by law to grant my request, but if they do so, they must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws and regulations.

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_

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Signature of Legal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if patient is a minor or unable to sign)

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Representative to the Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_