Nutrition Key™
Unlock Your Healing Potential

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NOTICE OF PRIVACY PRACTICE 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 may be directly and/or indirectly involved in that treatment;
- obtain medical records including medical assessments and lab test results;
- conduct normal healthcare operations such as quality assessments and physician certifications.

I have received a copy of the Notice of Privacy Practice containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request a written restriction on how my private information will be used or disclosed to carry out treatment, payment or health care operations. I also understand that Angela is not required to agree to my requested restrictions, but, if she does agree, she is bound to abide by my restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature: _____

Date: _____