



HIPAA ACKNOWLEDGEMENT NOTICE

PLEASE DO NOT SIGN THIS NOTICE UNTIL YOU HAVE COMPLETELY READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES

I understand that under the Health Information Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my Protected Health Information and how it is used. I understand that this information can and will be used by Matthews-Vu Medical Group and staff to carry out treatment, payment or healthcare operations.

I understand that I may refer to the Notice of Privacy Practices for a more complete description of these uses and disclosures. I acknowledge that I have been informed and read the Notice of Privacy Practices in its entirety prior to signing this consent.

I understand that I may request in writing that you restrict how my private information is used and disclosed. I also understand that the office of Matthews-Vu Medical Group are not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. I understand that if this request is granted and information needed to carry out payment for treatment is restricted, this office exercises its right to collect payment for those services in full prior to services being rendered. I also understand that it will be my responsibility to seek reimbursement for those services from my insurance company.

I understand that Matthews-Vu Medical Group reserves the right to amend the Notice of Privacy Practices from time to time and that I may, at any point, request a copy of the current Notice.

I understand that I may revoke this consent in writing at any time, except to the extent that the covered entity has taken action in reliance of prior consent and authorization. I understand the consent must be signed in person with the Privacy Officer or in written form and sent via certified return receipt mail to the attention of the Privacy Officer named.

Signature of Patient/Personal Representative

Date

Printed Name