Center for
NEUROSCIENCES

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices (NPP) explains my privacy rights under HIPAA, regarding my protected health information/medical records. My signature indicates that I have received or have been offered a copy of the NPP and I understand the NPP.

I also understand that:

- I can request a copy of the NPP at any time.
- Signing this Acknowledgement does not mean that I have agreed to any special use or sharing of my medical records.
- The NPP may be changed at any time. I may request a copy of the revised NPP.
- If I refuse to sign this form, my health information may still be disclosed, as allowed by HIPAA.

_____ *Patient Name (Please Print)*	_____ *Date of Birth*
_____ *Patient/Legal Guardian Signature* *Legal Guardian Name*: _____	_____ *Date*

PATIENT ACKNOWLEDGEMENT OF EMAIL USAGE

I agree to communications with the Center for Neurosciences (CNS) through email. I understand that anyone who can access my email, might have access to my Protected Health Information. My email address will not be given to other entities or businesses. **I understand that I am not required to provide Center for Neurosciences an email address.** Sign below if you agree to communication through email.

Patient/Legal Guardian Signature: _____

Email Address (Print Neatly): _____

If you agree to communications through email, print your email address

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OFFICE USE ONLY

____ *Initial if patient refuses to sign Acknowledgement of Receipt of NPP.*