TRANSFORMATION
WELLNESS TEAM

678-352-1948
RECEPTION.TWT@GMAIL.COM
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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I, ____, have received a copy of this office's Notice of Privacy Practices. I understand that 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 health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

Print Name: ____

Signature: ____ Date: ________________

FOR OFFICE USE ONLY:

If individual refused or was unable to sign, please indicate circumstances involved in the failure to obtain acknowledgement of Notice of Privacy Practices:

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