PRIVACY PRACTICE ACKNOWLEDGEMENT

I, _____ have been presented with a hard copy of Oregon City Family Practice Clinic, P.C. Notice of Privacy Practices also referred to as HIPAA. This policy details how my information may be used and disclosed as permitted under federal and state laws.

I understand the contents of the Privacy Practices (HIPAA) and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____

I hereby acknowledge receipt of the Notice of Privacy Practices for Oregon City Family Practice Clinic, P.C. I acknowledge understanding and agree to its terms.

Patient Signature: _____

Date: _____

POA/Guardian/Parent of Minor (Print):_____

Relationship: _____

Signature: _____