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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I understand that under the Health Insurance Portability and Accountability Act of 1996 (hereafter referred to as "HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received a copy of and have read and understand the Notice of Privacy Practices of the office of Michael G. Meyers, D.P.M. which contains a complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Privacy practices.

I understand that I may request in writing that this office restricts how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree with them, you are bound to abide by such restrictions.

To whom may we release your medical information:

1. ______________________________

2. ______________________________

3. ______________________________

____
Name of Patient (Printed)

____
Signature

____
(Relationship to Patient if Signed by Other than Patient)

____
Date