



ROBERT V. MORIARTY, M.D., F.A.A.O.S.

Sports Medicine and Orthopedics

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used for but not limited to the following;

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand the *Notice of Privacy Practices* containing a more complete description of the the uses and disclosures of my health information. I understand that Robert V Moriarty MD PC has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment payment or healthcare operations.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement of the Notice of Privacy Practices but was unable to do so as documented below;

Date	Initials	Reason

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