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*Cardiology and Internal Medicine*

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## ***Acknowledgment of Receipt for Notice of Privacy Practices***

*This Notice describes how medical information about you may be used and disclosed and how can get access to this information.*

*It contains information about your rights as a patient under HIPPA. It includes only Federal law and not State law. By signing this acknowledgement, you are stating that you have been offered a copy of this Notice in any format you choose as capable by our Practice. You also are stating that you have an understanding of the Notice of Privacy Practices.*

*At any time, you have the right to revoke your permission on how we use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosure we have already made with your permission and we ae required to retain our records of the care that we provided to you.*

*I give my consent for Dr. Insel to view my medication history online.*

*I acknowledge having received a copy of the Notice of Privacy Practices.*

| _____ | _____ | _____ |
|---|---|---|
| *Print Name* | *Sign Name* | *Date* |

*I choose not to sign this acknowledgement:*

| _____ | _____ | _____ |
|---|---|---|
| *Print Name* | *Sign Name* | *Date* |