NOTICE OF PRIVACY PRACTICES

https://www.toplinemd.com/practice-terms-policies/

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides me with certain rights regarding the privacy of my protected health information. I acknowledge that I have been provided access to the Practice's Notice of Privacy Practices through a QR code and/or website link and have been given the opportunity to review it. I understand that the Practice may revise its Notice of Privacy Practices from time to time and that I may access the most current version by using the QR code and/or website link.

Patient Signature: _____

Patient or Legal Guardian Name (print): _____

Date: _____

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____