INTEGRATED HEALTH ASSOCIATES

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

WRITTEN ACKNOWLEDGMENT FORM

I, _____ ("Patient") acknowledge that I have received, or have been offered the opportunity to receive a copy of **Integrated Health Associates'** Notice of Privacy Practices. I understand that the Notice describes how the medical office may use and disclose my protected health information, my rights regarding my health information, and the office's responsibilities concerning the privacy of my information.

I understand that I may review the Notice of Privacy Practices and may contact the office if I have questions or concerns regarding my privacy rights.

I understand that the medical office may revise its Notice of Privacy Practices from time to time and that I may request a current copy of the Notice.

I acknowledge that my signature does **not** constitute authorization for any use or disclosure of my protected health information beyond what is permitted or required by law.

_____ _____

Signature of Patient / Legal Guardian Date