NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

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

I understand I have access to your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I understand that Dr. Steven Bullard has the right to change his Notice of Privacy Practices from time to time and that I may contact him at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, and healthcare operations. I also understand that Dr. Steven Bullard is not required to agree to my requested restrictions, but if agreed upon, Dr. Steven Bullard is bound to abide by such restrictions.

_____	_____	_____
Name of Patient (Please Print)	Patient/Guardian Signature	Date

AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEATH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to the above Acknowledgement Form. The patient may desire other individuals such as family members to have access to their PHI. Use the spaces below to specify those individuals, their relationship to you, and any limitations (if any) on the extent of their access to your PHI (e.g., billing issues only), and any expiration date to that access:

Name	Relationship	Limitations/Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above mentioned protected health information may be subject to redisclosure by the party receiving the information and may no longer be protected by the privacy rules. By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Office of the Practice.

_____	_____	_____
Name of Patient (Please Print)	Patient/Guardian Signature	Date