

The Internal Medicine and Pediatric Clinic of New Albany, PLLC
Notice of Health Information Practices Sign-Off Form

By my signature below, I acknowledge that:

1. I have received a copy of the *Notice of Health Information Practices*.
2. I have read, or have had read to me, the entire *Notice of Health Information Practices* which:
 - a. States the normal uses and disclosures of patient information.
 - b. Outlines Internal Medicine & Pediatric Clinic's responsibilities under the HIPAA Privacy Rule.
 - c. Details my rights as a patient or legal representative of a patient.

The original of this *Notice of Health Information Practices Sign-Off Form* will be retained with my medical record and a copy will be made for my own personal records.

Signature of Patient or Legal Representative

Date and Time

Print Patient's Name

Print Name of Legal Representative (if applicable)

Relationship to Patient

The following people have permission to have access to the patient's health information and to make decisions on behalf of the patient if the patient is unable to make those decisions for himself/herself or in the absence of the patient's legal guardian. (Please print name and a contact phone #.)

