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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

For Office Use Only

Chart Number: _____

Patient (Please Print Name): _____ Date: _____

Authorized Representative (Printed Name): _____ Date: _____

I understand and have been provided with a Triangle Spine and Back Care Center Notice of Information Practices, that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing any consents and/or authorization forms. I understand that the organization reserves the right to change its notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

I have been provided and accepted a paper copy of the Notice of Privacy Practices for my personal records today.

I decline a copy of the Notice of Privacy Practices at this time, but understand that I may request a copy when desired.

Patient Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

For Office Use Only:

Patient provided with copy of NPP in the office Date: _____ Initials: _____

Patient request for NPP copy Date: _____ Initials: _____

Copy Mailed to patient Date: _____ Initials: _____

Other: _____