NOVELLO INFUSION
Healthcare Reimagined.

Acknowledgement of Receipt of HIPPA/Notice of Privacy Practices

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I understand that I have certain rights and privacy regarding my protected health information. These rights have been given to me under the health Insurance Portability and Accounting Act of 1996 (HIPPA). I understand that by signing this form I authorize you to use and disclose my protected health information to carry out

- Treatment (including direct or indirect) by other healthcare providers involved in my care.
- Obtain payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of Novello infusion Center.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most recent copy of this notice.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Signature of Patient or Personal Representative Date

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Printed Name of Above Signature

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Relation to Patient if Signed by Representative

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Novello Infusion Witness