Dr. Kenneth A. Godwin
301 Oxford Valley Road
Suite 903
Yardley, PA 19067

HIPAA Patient Acknowledgment Form

Patient's Name: _____ DOB: _____

Our *Notice of Privacy Practices* (NPP) provides information about how Godwin Plastic Surgery Center may use and disclose *protected health information* (PHI) about you. The practice provides this form to comply with the *Health Insurance Portability and Accountability Act* (HIPAA). The NPP contains a Patients' Rights section describing your rights under the law. Please review the NPP pamphlet thoroughly before signing this acknowledgement form. If terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment, and healthcare operations. You have the right to restrict how PHI is used or disclosed for treatment, payment or healthcare operations.

I give permission for Godwin Plastic Surgery Center to:

Leave a message regarding an appointment on my primary phone voicemail: ◯ Yes ◯ No

Leave a message regarding test results on my primary phone voicemail: ◯ Yes ◯ No

I give permission for Godwin Plastic Surgery Center to share medical information with:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Please check off the boxes below:

___ I assume responsibility to inform the practice of any changes in the above information.

___ I have received the most recent Notice of Privacy Practices (**NPP**) pamphlet.

Signature of Patient: _____

(Parent or Guardian, for minor child)

Date: _____