ANDREW P. GIACOBBE, MD, PC
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received your *Notice of Privacy Practices*. I understand that Dr. Giacobbe has the right to change his *Notice of Privacy Practices* and that I may contact the office 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

We at Dr. Giacobbe's office adhere to a strict confidentiality policy for your protection. Consequently, we will not divulge any information regarding your treatment, appointment dates, appointment times, test results, etc. without your written consent. In the space provided below, kindly **print clearly** any person/s to whom we may provide said information.

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financial companies, when requested, to facilitate your payment.

Name	Relationship	Phone number

Patient Name_____

Signature_____
Patient or Person Authorized to give consent for patient

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below.

Date:	Initials:	Reason: