HIPAA ACKNOWLEDGMENT FORM

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment in the operation of this practice. I understand that Dr. Federici is not required to agree to the restriction that I may request. Further, I understand that I have the right to review at any time Dr. Richard Federici's Policies and Practices to Protect the Privacy of Your Health Information which is posted in this office.

This form will serve as an acknowledgment that I have read the HIPAA notice form and understand that I have the right to revoke this consent, in writing at any time.

(A minors signature is required for patients 14 and older)

_____	_____	_____
Signature of Patient	**Print Name**	**Date**
_____	_____	_____
Signature & Relation if Not Patient	**Print Name**	**Date**