



Frank Feigenbaum, M.D., FAANS, FACS

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.
- Authorization to release medication history to SureScripts for prescribing purposes (allows communication with pharmacy).

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time, and that I may contact this organization at any time at the address above 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 to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient (or Custodian) Name & DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

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In accordance with *Feigenbaum Neurosurgery Privacy Practices*, I hereby authorize Feigenbaum Neurosurgery to communicate with my spouse, children, and/or parents regarding my care and I authorize representatives of FN to communicate with me via home answering machine, voice mail (work phone or cell phone), and/or E-mail unless I check this box:

I hereby authorize Feigenbaum Neurosurgery to communicate with the following people:

Name	Relationship
_____	_____

These authorizations will remain in effect until you send us written notice of your desire to revoke the authorizations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**OFFICE USE ONLY**

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

Date: _____	Prepared By: _____	Signature: _____
Reason:	_____ An emergency existed and a signature was not possible at the time.	
	_____ The individual refused to sign.	
	_____ A copy was mailed with a request for a signature by return mail.	
	_____ Unable to communicate with patient for following reason: _____	
	_____ Other: _____	

Revised May 2020