University of Tennessee Health Science Center
Acknowledgement of receipt of the Notice of Privacy Practices

I understand and have been provided with the Notice of Privacy Practices that tells me how my health information is used and to whom it is given.

I understand that I have the right to review the notice prior to signing this acknowledgement form.

I understand that the organization reserves the right to change their notice and practices that changes will be posted in the office and available to me on the web site.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that this request must be made in writing. UTHSC is not required to agree to the restrictions I request.

I understand that I may revoke this acknowledgement in writing, except to the extent that the organization has already taken action in the reliance thereon.

_____ _____
Signature of patient or legal representative Date

If representative, explain the relationship to the patient. _____

For Office Use Only