Joseph B. Boucree, Jr. M.D.

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ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I, ________________________________, acknowledge that I have received a copy of Joseph B. Boucree Jr., MD privacy notice.

I understand that a privacy officer has been appointed and that any questions regarding the privacy act may be directed to the HIPAA Privacy Officer.

I have read and understand the facility's privacy notice. I understand that I have the right to restrict how protected health information may be used. I also understand that the facility may refuse admission should the restrictions I place on my protected health information interfere with the ability to treat me; bill for services rendered or interfere with the operations of the facility.

______________________________ ______________________________
Signature of patient Date

______________________________ ______________________________
Signature of Facility Personnel Date