COMMUNITY CARE OF WEST VIRGINIA, INC. ("CCWV")

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand CCWV's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that CCWV has the right to change its *Notice of Privacy Practices* from time to time and that I may contact CCWV at any time to obtain a current copy of the *Notice of Privacy Practices*.

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

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

Date:	Initials:	Reason: