NIM Longevity
A Functional and Holistic Approach

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF HIPAA PRIVACY PRACTICES

I certify that I have received a copy of Newtown Internal Medicine's ("NIM") Notice of HIPAA Privacy Practices. The Notice of HIPAA Privacy Practices describes the types of uses and disclosures of my protected health information ("PHI") that might occur in the treatment, payment or performance of NIM's health care operations. The Notice of HIPAA Privacy Practices also describes my rights and NIM's duties with respect to my PHI. The Notice of HIPAA Privacy Practices is also posted in NIM's office at the address shown below.

NIM reserves the right to change its privacy practices that are described in the Notice of HIPAA Privacy Practices, as maybe be required by law, periodically. I may obtain NIM's revised Notice of HIPAA Privacy Practices by calling the office and requesting that a revised copy be sent via mail or e-mail or by asking for one at the time of my next appointment.

By signing this acknowledgement form, I consent to NIM's use and disclosure of my PHI for treatment, payment and healthcare operations. I understand that:

- PHI may be used or disclosed for treatment, payment and healthcare operations.
- NIM reserves the right to change its HIPAA Privacy Practices, as may be required by law.
- The patient/I has/have the right to restrict the use of its PHI, but NIM does not have to agree to those restrictions.
- The patient/I has/have the right to revoke this consent, in writing, on a going forward basis only.
- NIM has the right to condition any and all treatment and patient care upon execution of this acknowledgement and consent.

HOW MAY WE CONTACT YOU (please circle all that apply):

Call via telephone:	**Home:** yes / no	**Work:** yes / no	**Cell:** yes / no
Leave a voicemail:	**Home:** yes / no	**Work:** yes / no	**Cell:** yes / no
Email: yes / no	**Text:** yes / no	**Patient Portal:** yes / no	

May we discuss your medical condition and PHI with a relative, partner or friend?: yes / no
If yes, please complete the Authorization Disclosure Form, separately for each relative, partner or friend.

_____ ____/____/____
Signature of Patient / Patient Representative / Legal Guardian Date of Birth (Patient)

_____ ____/____/____
Print name of person signing this Form Today's Date

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