

HIPPA

Health Insurance Portability and Accountability

*You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of the Notice of Privacy Practices from the office of Dr.'s Tanaka, Leong and Yonan.

This notice explains how my health information may be used and disclosed, as well as my rights regarding that information. I understand that I can request a copy of the Notice of Privacy Practices at any time.

I, _____, have had a full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

If there is anyone you wish for us to release information regarding your account, please list their name(s) below:

_____	_____	_____
_____	_____	_____

Signature: _____ Date: _____

Staff Initials: _____