ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE

BODYWORKS

I understand that:

- In general, any information that is about your health and the care you receive or payment for that care is considered confidential and protected by our practice consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with regard to Protected Health Information (PHI).
- BODYWORKS needs to use your protected health information to carry out treatment, payment, health care operations, and/or other purposes. My signature below authorizes the release of pertinent medical records and information – on paper, in electronic form, or verbally.
- BODYWORKS' Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.
  A copy of BODYWORKS' Notice of Privacy Practices has been made available to me.
- PRAXIS CORPORATION will accommodate all reasonable requests for confidential communications. All communications will be routed to me using the information I verified on my Patient Referral Form.
  Are you requesting restricted communications? If so, please complete the Request for Restricted Communications form.

Patient Name: (Please print.) _____

Patient Signature: (OR, below) _____ Date: _____

Patient Representative/Signature: _____ Date: _____

Relationship To Patient: _____