PRIVACY NOTICE ACKNOWLEDGEMENT

Please sign below and return this form to The Stratford Health Department
468 Birdseye Street, Stratford, CT 06615

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my or my child's personal health information. I understand that this information can and will be used to:

- Conduct, plan and direct my or my child's treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from Third party administrators.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Privacy Notice*** containing a more complete description of the uses and disclosures of my health information. I understand that the Stratford Health Department has the right to change its' ***Privacy Notice*** from time to time, and that I may contact the Stratford Health Department at any time at the address above about how to obtain a current copy of the ***Privacy Notice.***

I understand that I may request in writing that you restrict how my or my child's private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print) _____

Patient's Date of Birth _____

Relationship to Patient (Self, Parent, guardian)_____

Signature _____

Date _____