

INSTITUTE FOR STRESS CONTROL  
501 W OGDEN AVENUE, SUITE 6  
HINSDALE, IL 60521  
630.920.0900

**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. 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 that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy* practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my 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:** \_\_\_\_\_

**Signature:** \_\_\_\_\_  
(Patient ages 12 and over sign)

**Parent/Guardian Signature and Relationship to Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date:	Initials:	Reason:
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