**Acknowledgement of Receipt of Notice**

**Privacy Practices**

Patient’s Name:

I understand that I can request a restriction on how my health information is used or disclosed to carry out treatment or health care operations. However, there may be times when James E. Dopson M.D., is not able to honor my requested restrictions. For example, they may need to release my medical information to get paid from an insurance company or to treat me.

I consent to the disclosure of my protected health information for the purpose of medical diagnosis, providing treatment , obtaining payment to conduct necessary health care operations, and authorize direct payment of medical insurance benefits to James E. Dopson, M.D., for services performed. I also understand and agree that I am responsible for payment of all valid charges not paid by my medical insurance.

I accept that there is no guarantee of protection of my medical record from a court ordered release. In the event of legal proceedings involving patient care, I understand the contents of my life must be made available to legal counsel representing the practice and professional employee.

I have received a copy of James E. Dopson, M.D.’s, Notice of Privacy Practices on the date listed below.

Patient’s Signature: Date:

Patient’s Name: Date: