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HIPAA NOTICE OF PRIVACY PRACTICE

Patient Consent and Acknowledgement of Receipt of Privacy Notice

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to Heather Stolworthy in person or by phone at (208) 287-0408.

_____ I acknowledge that I have read and agree with the Patient Consent and Acknowledgement of Receipt of Privacy Notice.
Please Intital

Patient Printed Name _____

Patient Signature _____ **Date** ____ / ____ / ____
mm dd yy

Witness Signature _____ **Date** ____ / ____ / ____
mm dd yy

HIPAA COMPLIANT