

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Horizon Prosthetics, LLC

6055 Lehman Drive, Suite 104 · Colorado Springs, CO 80918

By signing this form, I, _____ on _____
(PLEASE PRINT NAME) (TODAY'S DATE)

declare I reviewed Horizon Prosthetics, LLC notice on Patient Privacy Practices and Supplier Standards and authorize Horizon Prosthetics, LLC the use and disclosure of individually identifiable health information related to me. I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information as explained in the Patient Privacy Practices document. I understand Horizon Prosthetics, LLC has the right to change its Notice of Privacy Practices at any time and that I may contact Horizon Prosthetics, LLC to obtain a copy of the current privacy practices. I understand that the most current HIPAA document will be posted on the company's website, www.horizonprosthetics.com, at all times.

I understand I may request, in writing, certain restrictions on how my protected health information is used or disclosed. I also understand Horizon Prosthetics, LLC reserves the right to deny any requests on information restrictions; however, if Horizon Prosthetics, LLC approves my request, the restrictions will take effect immediately.

Signature: _____

If signature above is not the client, print name and state relationship to client:

If we are unable to speak to you by phone, may we leave a message on your voicemail? Yes No

May we leave a message with the person answering the phone? Yes No

If yes, I authorize messages to be taken by _____
PLEASE PRINT NAME/S

Relationship to Client _____

OFFICE USE ONLY

I, _____, attempted to obtain the client's signature in acknowledgement of receiving the Notice of Privacy Practices for Horizon Prosthetics, LLC, but was unable to do so as documented below:

Date:	Reason:
Horizon Representative Signature:	