The Center for Cranial & Spinal Surgery, P.C.
Donald G. Hope, M.D., F.A.C.S.

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 complete description of the uses and disclosures of my health information. I understand that the Center for Cranial & Spinal Surgery, P.C., 1830 Town Center Drive, #103, Reston, VA 20190, has the right to change its *Notice of Privacy Practices* from time to time and that I may contact The Center for Cranial & Spinal Surgery, P.C. at any time in writing at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions if it is not feasible for CCSS to ensure compliance or believe it will negatively impact the care The Center for Cranial & Spinal Surgery, P.C. provides.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Donald G. Hope, M.D.,F.A.C.S. T/A The Center for Cranial & Spinal Surgery, P.C., 1830 Town Center Drive, #103, Reston, VA 20190 , to furnish via mail, facsimile, or person, any information, reports, records or x-rays in conjunction with the treatment or consultation rendered to me by Donald G. Hope, M.D., to my referring or treating physician. And discuss my medical condition; or make appointments with a family member, spouse, domestic partner, companion or friend named below. **IF YOU DO NOT WISH TO NAME ANYONE, PLEASE PRINT NONE IN SPACE PROVIDED FOR NAME.**

NAME___________________________________ **RELATIONSHIP TO PATIENT**: ________________

- **Do not name referring or treating physician. This is automatic under the continuation of care section under HIPAA Guidelines.**
- **Do not name any legal or corporate entity.**

PATIENT SIGNATURE (or guardian) ____

(Printed Name) ____ Date ______________________20_____

OFFICE USE ONLY:

WITNESS: ____________________________________ Date ______________________20_____

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement Statement but was unable to do so as documented below:

Date: Initials: Reason: