

DeAnna Bullaro-Anderer, DO, FACOOG
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information, as outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this information can and will be used to:

Conduct, plan and direct my treatment, and also assist with 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 read and understand Dr. DeAnna Bullaro-Anderer Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that Dr. DeAnna Bullaro-Anderer has the right to change its Notice of Privacy Practices from time to time and that I may contact Dr. DeAnna Bullaro-Anderer at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing a requisition of particular restrictions that I would like applied to the use and disclosure of my private information as it is used to carry out treatment, payment, or healthcare options. I also understand Dr. DeAnna Bullaro-Anderer is not required to agree to my requested restrictions. However, if Dr. DeAnna Bullaro-Anderer does not agree, Dr. DeAnna Bullaro-Anderer is still bound to abide by such restrictions.

I agree that Dr. DeAnna Bullaro-Anderer may discuss my medical information or insurance information with:

_____ Relationship: _____

_____ Relationship: _____

Patient Name: _____ Date: _____

Signature: _____ Relationship: _____