



6319 Havelock Avenue  
Lincoln, Nebraska 68507  
(402) 325-0044

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I have been provided with HAVELOCK PHYSICAL THERAPY'S Notice of Privacy Practices that describes how my health information is used and shared.

I understand that HAVELOCK PHYSICAL THERAPY reserves the right to change this notice at any time. I may obtain a current copy by contacting the clinic or the billing office.

For appointment reminders, health care treatment options, billing concerns or other health services that may be of interest to me, HAVELOCK PHYSICAL THERAPY may contact me as noted below:

Havelock Physical Therapy may contact me at home: ☐Yes ☐No

- Home Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_
- OK to leave a message? ☐Yes ☐No

Havelock Physical Therapy may contact me at work: ☐Yes ☐No

- Work Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_
- OK to leave a message? ☐Yes ☐No

Havelock Physical Therapy may contact me on my cell phone: ☐Yes ☐No

- Cell Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_
- OK to leave a message? ☐Yes ☐No

This authorization will remain in effect until revoked in writing.

Copies of my chart or any other written information are not covered by this authorization.

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**Patient Name** *(Please print)*

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**Date**

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**Signature**

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**Relation** *(self, parent, guardian, etc.)*