THE ENDOCRINE CENTER
CONCIERGE MEDICINE

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, or have been provided access to, a copy of The Endocrine Center, PC Notice of Privacy Practices**.**

The Notice of Privacy Practices describes how my protected health information may be used and disclosed and explains my rights regarding my health information under the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and Virginia law.

I understand that I may request a paper or electronic copy of the Notice of Privacy Practices at any time.

I understand that The Endocrine Center, may revise its Notice of Privacy Practices as permitted or required by law. The current Notice of Privacy Practices will be available upon request, at the practice, and on the practice website.

Questions or concerns regarding the privacy of my health information or the Notice of Privacy Practices may be directed to:

The Endocrine Center
3025 Hamaker Court, Suite 400
Fairfax, VA 22031
Phone: (703) 873-7425 Email: info@novaendocenter.com

Patient Name: _____ **Date of Birth:** _____

Signature of Patient or Legal Representative: _____

Date: _____

FOR OFFICE USE ONLY
If the patient's acknowledgment could not be obtained, document the reason:

☐ Patient declined to sign
☐ Emergency treatment situation
☐ Other: _____

The Endocrine Center made a good-faith effort to provide the patient with the Notice of Privacy Practices and obtain acknowledgment of receipt.

Staff Name/Initials: _____ **Date:** _____