Acknowledgement of Receipt and Availability of Privacy Practices

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:

1. Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in my treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

Upon request, I can receive and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that **Linda Kiley, MD, Ultra Health & Wellness, LLC** has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address below to obtain a current copy of this notice. This Notice of Privacy Practices is also available on our website at www.ultrahw.com as well at our office.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my restrictions that I request, but you are bound by them.

It is important for us to honor the confidentiality between patient and physician.

Please check your preference below:

_____You may discuss my medical information ONLY WITH ME.

_____You may discuss my medical information with the following persons I give permission to discuss with:

1. _____Relationship _____
2. _____Relationship _____
3. _____Relationship _____

YES or NO You may leave medical information such as test results or appointment confirmations on my voice mail at:

CELL # _____ HOME #_____OTHER #_____

Signature_____Date _____

Witness_____

Linda Kiley, MD
Ultra Health & Wellness LLC
561-701-2841