Allergy Rheumatology Immunology Associates of North Texas - ARIANT, PLLC

Patient Name: _____ Patient Identifier # : _____

ACKNOWLEDGMENT OF THE RECEIPT OF

ARIANT, PLLC's

NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

ARIANT is furnishing you with the attached notice, which provides information about how ARIANT and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you acknowledge that you have received a copy of ARIANT's *Notice of Health Information Practices.*

_____ _____

(Signature of Patient or Legal Representative) (Date)

Your name if not the patient: _____

Your relationship to patient: _____

July 9th, 2018

(Effective Date of *Notice*)