Rachel Rubin-Toles, M.D.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability act of 1996 ("HIPPA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

I hereby acknowledge that I have been presented with a copy of Rachel Rubin-Toles, M.D.'s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

I (**do, do not**) want the office of Rachel Rubin-Toles, M.D. to contact me by telephone regarding appointment reminders, x-ray and lab results.

Please contact me at:

☐ Home phone: (_____) _____

☐ Work phone: (_____) _____

☐ Cell phone: (_____) _____

You (**may, may not**) leave me a message.

I understand that if I choose to bring a family member or a friend into the exam room with me, that my personal information will be discussed in front of this person. Further more I understand that if I ask Dr. Rubin-Toles any medical questions outside of the exam room it may be possible that other patients and staff will hear private information about me.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____