**AKNOWLEDGEMENT FORM for: Notice of Privacy Practices for Protected Health Information.**

I HAVE READ AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS CONCERNING THIS NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

Patient or Patients Representative

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date

**POLICY ON USE OF RECORDING DEVICES BY PATIENT IN OUR OFFICES**

**I.** To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited within our offices at any of our locations. This includes any audio/video equipment or use of cell phones for recording purposes.

A. The Health Insurance Portability and Accountability Act (HIPPA) grants privacy protection to patient’s records. Once a recording is made, it may be hard to ensure that it remains private.

B. Electronic recording infringes on the privacy rights of the licensed therapist and employees.

C. If it is discovered that you have electronically recorded any of the Community Rehab PT Centers staff, or any other patients in our office, we will withdraw you from our care. You are expected to abide by our policy while you are on our premises. Your understanding and compliance to this policy will be greatly appreciated.

Patient Signature :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_