Joel J. Angyal, D.C., D.A.A.P.M.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT

I understand that under the Health Information 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:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Notification of any breaches in unsecured Protected Health Information

I have received and read and understand your Notices of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Duo-Med Inc. /Joel J. Angyal, D.C., D.A.A.P.M, has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization to obtain a copy of the Notice of Privacy Practices.

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 health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

PRINT Patient Name:_____ Date of Birth:_____

Signature: X_____ Date:_____

I will allow Dr. Angyal or their designees to discuss my protected health information with the following person(s) listed below:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

FOR OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices but was unable to do so as documented below:

Date:_____ Initials:_____

Reason:_____
_____
_____

510 Anderson Ave, Cliffside Park, NJ 07010