FAL RIVER HEALTH CENTER, LLC
Integrative Medicine
Linda S. Grigel MHP, PA-C

HIPAA AGREEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that **Fal River Health Center, LLC** has given you a copy of its Notice of Privacy Practices for your perusal (and a copy of the document if you so desire). This notice explains how your personal health information (PHI) will be handled. HIPAA, the new Federal law concerning medical privacy requires this notice.

By signing below, I agree that I have read a copy of the Notice of Privacy Practices, and that this office has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

IF PATIENT IS A MINOR

Parent / Guardian's Name (print): _____

Relation to Patient: _____

Parent / Guardian Signature: _____

Date: _____