Z-ADULT CLINICAL PRACTICE

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPPA and Consent for

Use of Health Information

Name _____ **Date** _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPPA and has been advised that a full copy of this office's HIPPA Compliance Information is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practice Pursuant to HIPPA, the HIPPA Compliance Information, State Law and Federal Law.

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Dated this_____**day of**_____**, 20**_____

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law

By _____
Signature of Parent/Guardian (circle one)