



**ACKNOWLEDGEMENT OF RECEIPT OF THE
FAMILY PHYSICIANS OF O'FALLON, P.C. NOTICE OF PRIVACY POLICIES**

As you may know, the U.S. Department of Health and Human Services (HHS) recently enacted regulations under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), which require health care providers to maintain the privacy/confidentiality of your individually identifiable health information (PHI). The protection of your health information is important to Family Physicians of O'Fallon, P.C.

Attached is a copy of the Family Physicians of O'Fallon, P.C. Notice of Privacy Practices which describes your health information privacy rights. We encourage you to thoroughly review this document and become familiar with how your personal health information will be used and safeguarded, as well as your rights regarding the protection of your personal data. The information in this notice became effective April 14, 2003.

I hereby acknowledge receipt of the Family Physicians of O'Fallon, P.C. Notice of Privacy Practices. I received and reviewed a copy of this notice on the date indicated below. I understand that if I have questions about this notice, I may contact the Family Physicians of O'Fallon, P.C. Privacy Officer at Family Physicians of O'Fallon, P.C., 310 N. Seven Hills Rd., O'Fallon, IL 62269, or by phone a (618) 624-6181.

DATE	PATIENT NAME (Print)	PATIENT SIGNATURE
SIGNATURE OF PERSONAL REPRESENTATIVE	RELATIONSHIP TO PATIENT	WITNESS

***WITNESS SIGNATURE REQUIRED IF SIGNED BY INDIVIDUAL OTHER THAN PATIENT**

Office Use Only

The Family Physicians of O'Fallon, P.C. Notice of Privacy Practices provided to patient _____ . Upon review patient/patient representative refused to sign acknowledgement of receipt of Notice of Privacy Practices.

PATIENT NAME (Print)

DATE	WITNESS SIGNATURE	2 ND WITNESS SIGNATURE
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***SIGNATURE OF 2 WITNESSES DESIRED BUT NOT REQUIRED**