HIPAA (Health Insurance Portability and Accountability Act)
Notice of Privacy Practices

I. ***I hereby understand and acknowledge the following:***

- I am not required to sign this notice and may in fact refuse to sign this notice.
- Dr. Miller will not condition my treatment or receive payment for my treatment on obtaining this from me, unless permitted by law.
- If the organization or person authorized to receive information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
- I have the right to revoke this notice at any time. My revocation must be in writing and submitted to Dr. Miller's office. If I do revoke this authorization, however, my revocation will not effect any prior actions.
- If I have any questions about this notice, I may contact Dr. Millers office at: 1485 E 3900 South, Suite 103, Salt Lake City, Utah 84124; (801)277-1087 who will then provide me with more information about Dr. Miller's privacy practices.

II **The following persons or organizations are authorized to make the requested use or disclose of my protected health information above:** (i.e. family members, caretakers, etc.)

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I certify that I have read and signed Dr. Miller's Privacy Practices.

____ ____________
Signature of patient (or patient's representative) Date

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Relationship of patient representative to patient

Office use only:
Patient Refused __________