## FORM-2: Acknowledgement of HIPAA Receipt

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The HIPAA guidelines state that your private health care information will not be shared with anyone without your consent. A full copy of the HIPAA guidelines is being made available to you today for your review (FORM-9).

By signing this document, I acknowledge that I was offered a copy of the notice of privacy practices (HIPAA) and understand its content.

I hereby give my consent for Huber Personalized Medicine and any appropriate affiliates to release my protected health information to the following individuals or family members:

Self only: _____

_____Relationship to Patient_____

_____Relationship to Patient_____

Primary Care Physician: _____

Other Physician: _____

_____

**Print Name: _____**

**Signature: _____** SEP

**Date: _____**

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