# HIPAA ACKNOWLEDGEMENT FORM

Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, "Office" shall refer to: ***Art of Anatomy, LLC***

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

By checking the box, "I acknowledge Art of Anatomy's compliance with HIPAA." on the online intake form (https://esportshealthcare.com/aoa-intake/), I am agreeing to the terms described on this document.

By checking the box, "Approval of signature: I confirm my digital signature," on the online intake form (https://esportshealthcare.com/aoa-intake/), I also agree and authorize that my digital signature will be used in place of a handwritten signature.