HIPAA Notice of Privacy Practices Acknowledgment Form

I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "**Notice**") for the Clears Clinic Corporation and that I have been provided an opportunity to review it. I understand that:

- I have certain rights to privacy regarding my protected health information.
- The Clears Clinic Corporation may use my health information for purposes of my treatment and health care operations.
- The Notice explains in more detail how the Clears Clinic Corporation may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- The Clears Clinic Corporation has the right to change the Notice from time to time, and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

Name: _____ Date:_____

Signature: _____ Date of Birth:_____

Relationship to Patient: _____