ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGANTION OF DISCLOSURE

I. Acknowledgement of HIPAA Privacy Notice:

I have received a copy of the Notice of HIPAA Privacy for the Physician Practice.

_____	_____	_____	_____
Name of Patient (adult)	Date of Birth	Signature of Patient	Date

II. Designation of Disclosure:

Sign in sheet: Our office uses a sign in sheet. If you have any objection to signing your name on the sheet; please tell our office staff and she will assign you a number.

Appointment reminders:

I give the office permission to send a reminder **postcard** to my home. **Yes ___ No ___**

I give the office permission to call me and remind me of an appointment. **Yes ___ No ___**

( ) Please call my home phone: _____

( ) Please call my cell phone: _____

If we get a voice mail, may we leave a brief message? **Yes ___ No___**

If we get a family member, may we leave a message? **Yes ___ No ___**

If yes, please indicate who we may leave a message with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Test Results (laboratory, X-ray, etc.): Our office will call you when we receive test results.

We will make every attempt to reach you personally. If we cannot reach you personally:

May we leave a message on the voice mail to have you call the office? **Yes ___ No ___**

May we leave routine test result(s) on your voice mail? **Yes ___ No ___**

Policy for discussing medical information: Our office will not discuss your medical information with any family member unless you have authorized us to do so.

Designation of Certain Relatives and Other Caregivers: I agree that the practice may disclose certain of my health information to a family member, or other caregiver; since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I hereby designate the following persons listed below as persons involved with my health care or payment relating to my health care. I understand that I may change this list at any time in writing.

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Signature_____ **Date**_____