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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

1. Acknowledgement of Practice’s Notice of Privacy Practices:

By subscribing my name below I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian
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2. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person’s involvement with my healthcare or payment relating to my healthcare.

Print Name: _____ DOB or other Identifier: _____

Print Name: _____ DOB or other Identifier: _____

3. Request to receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home Telephone Number
 Ok to leave message with detailed information or Leave Message with callback number only

Work Telephone Number
 Ok to leave message with detailed information or Leave Message with callback number only

Cell Telephone Number
 Ok to leave message with detailed information or Leave Message with callback number only

Fax Telephone Number
 Ok to leave message with detailed information Email 1: _____

Email
 Ok to email to address(s) Email 2: _____

Patient Name	Patient Signature	Date
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<p>1. The above authorizations are voluntary and I may refuse their terms without affecting any of my rights to receive healthcare at the Practice.</p> <p>2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice’s mailing address marked to the attention of “HIPAA Compliance Officer.”</p> <p>3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.</p>	<p>4. I may see and copy the information described in this form. I can obtain a copy after I sign it, if I so request it.</p> <p>5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.</p> <p>6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.</p>
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