PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Patient Name: _____ DOB: ____/____/_____ Todays Date: ____/____/_____

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 or understand I can always request a copy. I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

_____ Date: _____/_____/_____
Signature of Patient or Personal Representative

_____ _____
If Not Signed by Patient Print Name of Personal Rep Description of Personal Representative's Authority

Above signature was not obtained because of the following:

- ☐ Patient is unable to sign and is unaccompanied by a representative. Patient left with all pertinent disclosures.
- ☐ Patient refused to sign
- ☐ Patient refused the forms

Designation of Certain Relatives, Close Friend or Caregivers as my Personal Representative

I agree that the practice may disclose certain sections of my health information to a Personal Representative of my choosing, since such person is involved with my health care 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 health care or payment relating to my health care.

Print Name	Relationship to you	Telephone	What we may disclose
			☐ Any and All Information ☐ Other_____
			☐ Any and All Information ☐ Other _____
			☐ Any and All Information ☐ Other_____

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 by the alternative means that I have listed below:

Home Phone		☐ OK to leave message with detailed information ☐ Leave message with call back numbers only
Cell Phone		☐ Ok to leave message with detailed information ☐ Leave message with call back number only

_____ _____/_____/_____
Signature of Patient Date

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