PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I.   **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**   **Patient Chart number**

II.   **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 health care.

Name:_____   Relationship: _____   Phone Number: _____
Name:_____   Relationship: _____   Phone Number: _____

III.   **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 or Cell Telephone Number(s):

_____   _____
_____ OK to leave message with detailed information   _____ OK to mail to address listed above
_____ Leave message with call back numbers only   _____ E-mail me at:_____

     Other:_____

1.   The above authorizations are voluntary, and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.

2.   These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."

3.   The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4.   I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5.   This form was filled in before I signed it and I acknowledge that all my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6.   This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____   _____
Patient Signature   Date