PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. HIPAA Acknowledgement (*Notice of Privacy Practices*):

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that 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.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain 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 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.

Print Name: _____ Last four digits of his/her SSN (required):_____
Print Name: _____ Last four digits of his/her SSN (required):_____
Print Name: _____ Last four digits of his/her SSN (required):_____

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 Telephone Number:

_____

☐ OK to leave message with detailed information
☐ Leave message with call back numbers only

Written Communication Address:

_____

☐ OK to mail to address listed above
☐ Email me at: _____

Work Telephone Number:

_____

☐ OK to leave message with detailed information
☐ Leave message with call back numbers only

Fax Communication:

_____

☐ OK to mail to address listed above
☐ Email me at: _____

Other: _____

Name of Patient (Print) **Signature** **Date**

Witness: _____ **Date:** _____