ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE
AND DESIGNATION OF DISCLOSURE

MEDICAL RECORDS

As per HIPAA regulations, your personal protected health information (PHI) will be held in strict confidence. Information will not be provided to a third party (attorney, etc.) or used for any purpose other than treatment, payment and healthcare operations unless we have a written authorization signed by you and a written request from the third party.

1. Acknowledgment of Practice's Notice of HIPAA Privacy:
I have been informed of the Notice of HIPAA Privacy for the Physician Practice. Copies of the notice are available upon request.

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

2. Designation of Certain Relatives, Close Friends and Other Caregivers:
A. I agree that the practice may disclose certain health information to a family member, close personal friend or other caregiver, since such person is involved with 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 wish to be contacted in the following manner (check all that apply):

Telephone, Written and Fax Communication

Home Telephone Number:
_____
___OK to leave message with detailed information
___Leave message with call back numbers only

Work Telephone Number:
_____
___OK to leave message with detailed information
___Leave message with call back numbers only

Written Communication:
___OK to mail to my home address
___OK to mail to my work/office address

Fax Communication:
___OK to fax to this number: _____
Other: _____

B. I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing:

Print Name: _____ Print Name _____
Print Name: _____ Print Name: _____

C. The following person(s) are not authorized to receive my Patient Health Information:
Print Name:_____ Print Name:_____

_____ _____
Signature of Patient/Parent/Guardian Date

D: In an emergency please contact: _____ _____
Name Relationship
Telephone No: _____ Cell Phone No: _____

How did you hear about us? Physician [ ] Insurance Co [ ] Yellow Pages [ ] Online search/website [ ]
Other [ ] Explain: _____