

**ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE
AND DESIGNATION OF DISCLOSURE**

I. Acknowledgment of Practice's Notice of HIPAA Privacy:

I have received a copy of the Notice of HIPAA Privacy for the Physician Practice.

Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date
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II. Designation of Certain Relatives, Close Friends and Other Caregivers:

A. I agree that the practice may disclose certain of my health-information to a family member, close personal friend or other caregiver, 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. I wish to be contacted in the following manner (check all that apply):

Telephone, Written and Fax Communication

Home Telephone Number: _____	Written Communication: _____
<input type="checkbox"/> OK to leave message with detailed information	OK to mail to my home address
<input type="checkbox"/> Leave message with call back numbers only	OK to mail to my work/office address

Work Telephone Number: _____	Fax Communication: _____
<input type="checkbox"/> OK to leave message with detailed information	OK to fax to this number: _____
<input type="checkbox"/> Leave message with call back numbers only	

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

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

Print name: _____ Print name: _____

Signature of Patient/Parent/Guardian Date

III. The Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

Date of disclosure request	Disclosed to whom; address/fax number	Description of disclosure	Purpose of disclosure	Dates of service of disclosure	Person completing request	Date completed