ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

PATIENT NAME: ___________________________ DOB: __________________

I designate the following person(s) listed below to correspond and receive my protected health information. I understand that I am not required to list anyone other than myself unless I choose to. I also understand that I may request to change this list at any time in writing.

Name: ________________________________ **Relationship** ___________ **Phone Number** ______________________

Name: ________________________________ **Relationship** ___________ **Phone Number** ______________________

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE CHECK ALL THAT APPLY)

Primary Phone Number _________________________________ Home Cell or Work

Secondary Phone Number ______________________________ Home Cell or Work

OK to leave messages including personal medical information? ◯ YES ◯ NO

OK to leave messages asking you to call us back? ◯ YES ◯ NO

OK to send on Patient Portal? ◯ YES ◯ NO E-Mail Address ________________________________

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SIGNATURE OF PATIENT

_______________________________ **NAME** ________________________ **RELATIONSHIP**_________
(IF UNDER 18 PARENT OR GUARDIAN SIGNATURE, NAME AND RELATIONSHIP)

I ACKNOWLEDGE I HAVE READ THE NOTICE OF PRIVACY PRACTICES.