HIPAA PRIVACY NOTICE

I. **Acknowledgement of Practice's Notice of HIPAA Privacy**

_____ _____
Name of Patient Date of Birth

_____ _____
Signature of Patient/Parent/Guardian Date

II. **Designation of Certain Relatives, Close Friends, Care Givers**

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 a person is involved with my health care or payment relating to my health care. In that case, the Physical 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(s):

Home Phone: _____

Check: ☐ Ok to leave message with detailed information
☐ Leave call back numbers only

Work Phone: _____

Check: ☐ Ok to leave message with detailed information
☐ Leave call back numbers only

Cell Phone: _____

Check: ☐ Ok to leave message with detailed information
☐ Leave call back numbers only

Written Communication:

Check: ☐ Ok to mail my home address
☐ Not ok to mail my home address

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: _____