PRIVACY PRACTICES ACKNOWLEDGMENT AND PREFERENCES

SEPTEMBER 2013

You have the right to restrict the disclosure of your protected health information as set forth in our *Notice of Privacy Practices*.

Please circle an answer for each question

- Were you offered a copy of our Notice of Privacy Practices? YES ☐ NO ☐
- Do we have permission to mail test results/ records to your home? YES ☐ NO ☐
- Do we have permission to leave a message on your **HOME** phone regarding the following information? :

Appointments YES ☐ NO ☐

Billing Information YES ☐ NO ☐

Medical Information YES ☐ NO ☐

- Do we have permission to leave a message at your **WORK** phone regarding the following information? :

N/A - I do not work outside my home.

Appointments YES ☐ NO ☐

Billing Information YES ☐ NO ☐

Medical Information YES ☐ NO ☐

Please DO NOT RELEASE MY PHI to the following persons, companies or physicians:

_____

_____

_____

_____

Please list at least 1 Emergency Contact:

_____

Name Phone

_____

Name Phone

MY SIGNATURE BELOW VERIFIES THAT I HAVE READ AND UNDERSTAND THIS FORM AND MY RIGHTS TO PRIVACY.

_____

Patient Name- PLEASE PRINT

_____

Patient's Signature Date

If the patient is a minor or unable to sign, a parent, guardian or person with POA should sign below.

_____

Printed name of signer Relationship

_____

Signature Date