Patient HIPAA Acknowledgement and Designation Disclosure Form

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By signing below, I acknowledge that I was provided the opportunity to review the Notice of Privacy Practices to read if I so choose, and that I understand and agree to the terms therein.

II. Designation of Personal Representative(s):

I agree that the practice may disclose my health information to the representative(s) list below; only that information directly related to this person's involvement or payment relating to my care will be disclosed.

Printed Name of Representative(s): _____

_____

_____

III. Unencrypted messages to alternative means of communication:

We offer administrative notifications (like appointment reminders) by regular text messages and email. There is some level of risk that these messages could be read by someone besides yourself. Please indicate your communication preferences below:

____ YES – Please communicate with me by email at: _____

____ NO – Do NOT communicate with me by unencrypted email

____ YES – Please communicate with me by text message at (___) _____

_____NO – Do NOT communicate with me by text message

_____ You may fax information to me at (___) _____

_____ You may leave me a voice mail (with call back number only) at (___) _____

(no *detailed* information will ever be left in a voice message—this is a violation of HIPAA laws)

******For my security, I will notify you immediately if my email or cell phone number changes.**

IV. The following person(s) may NOT receive my Patient Health Information (PHI):

_____

(printed name(s) of unauthorized person(s)

1. The above authorizations are voluntary and do not affect any of my rights to receive healthcare.
2. The authorizations may be revoked at any time by notifying the practice in writing.
3. Revocation of authorizations does not affect disclosures prior to revocation.
4. This form was completely filled in per my direction prior to my signing it, and I may request a copy of it at any time.
5. These authorizations remain valid until changed or revoked by me or my designated Power of Attorney.

_____

Printed name of Patient **date of birth**

_____

Signature of Patient/Parent/Legal Guardian **date**