IX. ACKNOWLEDGEMENT OF PRACTICE'S NOTICE OF HIPAA POLICY:

I hereby acknowledge that I have received my Provider's HIPAA Notice of Privacy Practices as of the date of the first service delivery, or as soon are reasonably practicable in the event that I received emergency treatment.

Patient's Name: _____ Patient D.O.B.: _____

Your Signature: _____ **Date:** _____

If you are a Legally Authorized Representative Signing on behalf of a patient, complete the following:

Print Your Name: _____

Indicate Your Relationship (check one): ☐ Parent ☐ Spouse ☐ Guardian

☐ Power of Attorney ☐ Other: _____

X. 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

Please Rank in your order of Preference (1-7)

◯ **Home Phone Number:** _____
☐ OK to leave message with detailed information ☐ Leave message with call back number only

◯ **Cell Phone Number:** _____
☐ OK to leave message with detailed information ☐ Leave message with call back number only

◯ **Work Phone Number:** _____
☐ OK to leave message with detailed information ☐ Leave message with call back number only

◯ **Written Communication:**
☐ OK to mail to my Home Address ☐ OK to mail to my Work Address

◯ **Fax Communication:**
☐ OK to fax to this number: _____

◯ **Email Communication:**
☐ OK to send email to this address: _____

◯ **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: _____ Representative's Phone Number _____

Print Name: _____ Representative's Phone Number _____

Print Name: _____ Representative's Phone Number _____

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

Print Name: _____ Print Name: _____

Print Name: _____ Print Name: _____