

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 as 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: _____