FREEMAN SPINE & ORTHOPEDIC MEDICINE

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ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

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

I have received a copy of the Notice of HIPAA Privacy for the Physician Practice.

_____ _____ _____ _____
Name of Patient Date of Birth Signature of Patient/Parent/Guardian Date

II. **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

Home Telephone Number:

_____
☐ OK to leave message with detailed information
☐ Leave message with call back numbers only

Written Communication:

_____
☐ OK to mail to my home address
☐ OK to mail to my work/office address

Work Telephone Number:

_____
☐ OK to leave message with detailed information
☐ Leave message with call back numbers only

Fax Communication:

_____
☐ OK to fax to this number
Other: _____

B. I designate the following persons listed below as persons involved with my health care or payments relating to my health care for the purpose of the practice making the limited disclosures describes 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:_____ Last 4 digits of his/her SS Number (required) _____
Print Name:_____ Last 4 digits of his/her SS Number (required) _____
Print Name:_____ Last 4 digits of his/her SS Number (required) _____

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

Print Name:_____ Print Name:_____

III. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to th essary to accomplish the intended purpose. These provisions do not apply to uses or disc rsuant to an authorization requested by the patient/parent/guardian. Healthc keep a record of Patient health Information disclosures. Uses and disclosures for Treatr d Health Care Operations may be permitted without prior consent.

June 2013

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_____ _____
Signature of Patient/Parent/Guardian Date