ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

AND DESIGNATION OF DISCLOSURE

Acknowledgment of Practice’s Notice of HIPAA Privacy:

I have reviewed a copy of the Notice of HIPAA Privacy for Caring Doctors Medical Center.

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

Telephone and Written Communication

Home Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ leave message with detailed information

\_\_ leave message with call back number only

Work/Cell Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_leave message with detailed information

\_\_leave message with call back number only

Written Communication

\_\_mail to my home address

Designation of Certain Relatives, Friends and Other Caregivers:

I agree that the Caring Doctors Medical Center may disclose certain health information to the designated person I have chosen below, because this person is involved with my health care or payment relating to my health care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone Number