

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES / USE AND DISCLOSURE FORM**

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Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

Signature of Patient or Legal Representative

Date

Printed Name of Patient

Legal Relationship to the Patient

2

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. **Please list below names of the individuals you authorize our office to discuss care with.**

I give you permission to share my health information with:

1. Name of Primary Care Physician _____ Phone _____
2. Name _____ Relationship _____ Phone _____
3. Name _____ Relationship _____ Phone _____
4. Name _____ Relationship _____ Phone _____

Consent to email or text for appointment reminders and other healthcare communication.

3

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ I decline to receive communications via text.

_____ I decline to receive communications via email.

Patient signature _____ Date requested: _____

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice.