PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

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

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

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

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, 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.

Print Name:_____ **Last four digits SSN (required):**_____
Print Name:_____ **Last four digits SSN (required):**_____
Print Name:_____ **Last four digits SSN (required):**_____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: _____

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

Written Communication Address: _____

____ OK to mail to address listed above
____ E-mail me at:_____

Work Telephone Number: _____

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

Fax Number: _____

____ OK to Fax at the number listed above
____ E-mail me at:_____

Other:_____

_____	_____
Name of Patient (Printed)	Signature of Patient/Parent/Guardian
_____	_____
Witness signature	Date