

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices



This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the “Notice of Privacy Practices”

Name of Patient (Print)

Signature of Patient

Date of Signature

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave **messages** on a voice mail at work? Yes No N/A

May we discuss your **appointments/treatment** with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children? Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in the patient’s medical record.