# PATIENT HIPAA ACKNOWLEGEMENT 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 (NNP), and that I have read (or had the opportunity to read if I chose) and understand the Notice of Privacy practices (NNP) and to its terms.

____________________ __________ ______________________________

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

**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:____________________ Relationship to Patient____________________
Print Name:____________________ Relationship to Patient____________________
Print Name:____________________ Relationship to Patient____________________
Print Name:____________________ Relationship to Patient____________________

**III. Request to Receive Confidential Communications Alternative Means:**
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communication to me by the alternative means that I have listed below.

**Home Telephone Number**

______________________________

___Okay to leave message with detailed information
___Leave message with call back number only

**Work Telephone Number**

______________________________

___Okay to leave message with detailed information
___Leave message with call back numbers only

**Cell Telephone Number**

______________________________

___Okay to leave message with detailed information
___Leave message with call back number only

**Written Communication Address:**

______________________________

___Okay to mail to address listed above

**Other:**________________________________________

______________________________ ______________________________

Name of Patient (Print) | Signature | Date

______________________________ ______________________________

Witness | Date