

PATIENT HIPAA ACKNOWLEGEMENT AND DESIGNATION DISCLOSURE FORM

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		Acknowledgement of Practice's Notice of Privacy Practices:			
H. 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 of the Physician Practice will disclose only information that is directly relevant to the person's involvement winy health care or payment relating to my health care. Print Name: Print Name: Print Name: Relationship to Patient HII. Request to Receive Confidential Communications Afternative 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 cell back number only Written Communication Address: Okay to mail to address listed above Other: Other:		Practices (NNP), and that I have read (or had	the opportunity to read if I chose) and understa		
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