

# **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 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: Last four digits of his/her SSN (required):**

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**Print Name: Last four digits of his/her 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: Written Communication Address:**

OK to leave message with detailed information OK to mail to address listed above

Leave message with call back numbers only E-mail me at:

### **Work Telephone Number: Fax Communication:**

OK to leave message with detailed information OK to Fax at the number listed above

Leave message with call back numbers only E-mail me at:

### **Other:**

\_\_\_\_\_

\_\_\_\_\_  
Name of Patient (Print) Signature Date

Witness: \_\_\_\_\_ Date: \_\_\_\_\_