HIPAA Notice of Privacy Practices Acknowledgment and Questionnaire

- Please list family members or other persons, if any, whom we may inform about your general medical condition, your diagnosis and any billing questions (including treatment, payment and healthcare operations). **As a reminder these will be the only people we will be able to speak to or release any information to regarding your account.**

  Name:_________________________ Phone#:_____________________

  Name:_________________________ Phone#:_____________________

  Name:_________________________ Phone#:_____________________

  Name:_________________________ Phone#:_____________________

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

  YES_______________NO_______________

- Please indicate if we may mail your appointment reminder postcard via the mail?

  YES_______________NO_______________

By signing this form, I freely consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

_______________________________________ _________________________

Patient Signature Date