

# **HIPAA FORM**

## **Keeping Your Personal Health Information Private**

Home/daytime contact phone number: \_\_\_\_\_

May we leave a message with other residents? \_\_\_\_\_ Yes \_\_\_\_\_ No

May we leave a message on your home answering/voicemail? \_\_\_\_\_ Yes \_\_\_\_\_ No

### **To whom may we talk to about your medical treatment?**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Cell No. \_\_\_\_\_

Other Phone No. \_\_\_\_\_

Is this person an emergency contact also? \_\_\_\_\_ Yes \_\_\_\_\_ No

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Cell No. \_\_\_\_\_

Other Phone No. \_\_\_\_\_

Is this person an emergency contact also? \_\_\_\_\_ Yes \_\_\_\_\_ No

**If any of the above information changes, it is the Patient/Parent/Legal Guardian's responsibility to contact our office.**

Patient/Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient/Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

*Revised 2/18/2009*