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Patient Acknowledgement Form

PATIENT ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing the consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

Patient (or Authorized Representative) Signature: _____ Date: _____

AUTHORIZATION DISCLOSURE FORM (OPTIONAL)

In general, the HIPAA privacy rule gives individuals the right to request uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home or discussing PHI with family members.

*****PLEASE NOTE THAT YOU RETAIN THE RIGHT TO REVOKE OR CHANGE THIS CONSENT. REFOCATIONS AND CHANGES MUST BE SUBMITTED IN WRITING. THE REVOCATION AND/OR ITS CHANGES SHALL BE EFFECTIVE EXCEPT TO THE EXTENT THAT DHG HAS ALREADY TAKEN ACTION BASED ON THE PRIOR CONSENT.***

Individuals you authorize HIPAA to disclose specific PHI:
*****BY LAW WE DO NOT DISCLOSE ANY INFORMATION CONTAINING DRUG, ALCOHOL, MENTAL HEALTH STATUS, OR SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV/AIDS RELATED INFORMATION BY PHONE TO ANYONE.***

Name	Relationship	Please Check:
		☐ Appointments ☐ Lab results ☐ Medication ☐ Diagnosis
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Patient (or Authorized Representative) Signature: _____ Date: _____

*****PLEASE COMPLETE ALL PAGES*****