howard center
FOR WOMEN'S HEALTH

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 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)

_____ _____

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.

Telephone Number: _____

[ ] OK to leave message with detailed information [ ] Leave message with appointment information
[ ] Leave message with call back numbers only

E-mail me at: _____

Physical address _____

[ ] OK to mail to address listed above

Other: _____

IV. Signature

_____ _____ _____

Name of Patient (Print) | Signature | Date

_____ _____

Witness | Date