Notice of Privacy Practices Acknowledgment

◘ *I acknowledge I have received and reviewed the Notice of Privacy Practices Policy. My signature indicates I agree and read this policy.(If submitting electronic, I agree my electronic signature is binding and enforceable.*

Name: ___________________________________ **DOB:** ________________________________

Address: ____

City: _________________________ **State:** _____ **Zip code:** ______________________

PATIENT RECORD DISCLOSURES;

I understand HIPPA a privacy rule gives individuals the right to request a restriction on use and disclosure of their Protected Health Information (PHI). I further acknowledge, I have the right to request confidential communication or that a communication of PHI be provided by alternative means, to include but not limited to, a specified address other than my residence.

Communication:

I prefer to be contacted in the following manner: *(Please check your preference)*

◘ Home Phone: (   ) _________________________

◘ I give permission to leave detailed messages on this number.

◘ Leave a message with *call back information only*!

◘ Mobile Phone: *(Please check your preference)*

◘ I give permission to leave detailed messages on this number.

◘ Leave a message with *call back information only*!

◘ I give permission to leave detailed text messages on this number.

◘ E Mail Messages: *(Please check your preference)*

◘ I give permission to leave detailed email messages.

◘ Leave an email message with *information to contact office only*!

000.-+Client/Guardian Signature: ______________________________________

Date:__________