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## ACKNOWLEDGMENT OF PRIVACY PRACTICES

The HIPAA privacy rules give individuals the right to request communication of protected health information (PHI) be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I prefer to be contacted in the following manner (check all that apply):

**Home Phone** \_\_\_\_\_

\_\_\_\_ OK to leave message w/detailed information

\_\_\_\_ Leave message w/call-back number only

**Work Phone** \_\_\_\_\_

\_\_\_\_ OK to leave message w/detailed information

\_\_\_\_ Leave message w/call-back number only

**Cell Phone** \_\_\_\_\_

\_\_\_\_ OK to leave message w/detailed information

\_\_\_\_ Leave message w/call-back number only

**Written Communication**

\_\_\_\_ OK to mail to home address \_\_\_\_\_

\_\_\_\_ OK to mail to work address \_\_\_\_\_

\_\_\_\_ OK to fax to this number \_\_\_\_\_

\_\_\_\_ OK to email to this address \_\_\_\_\_

**Verbal Communication**

\_\_\_\_ OK to release information verbally to \_\_\_\_\_

I acknowledge a complete copy of the Notice of Privacy Practices has been made available to me.

Printed Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this acknowledgement is not signed by the patient complete the following:

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_