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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: _____