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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/Emergency Contact**
****Name/Phone#/Relationship****

OK to release information 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: _____