PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION AND DISCLOSURE FORM

I. Acknowledgement of Ankle & Foot Care 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 (NPP) and agree to its terms.

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name: _____ **Relationship/Phone #:** _____

Print Name: _____ **Relationship/Phone #:** _____

Print Name: _____ **Relationship/Phone #:** _____

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 as I have listed below:

Home Phone number: _____
[__] OK to leave a message with detailed information [__] Leave message with call back number only

Cell Phone number: _____
[__] OK to leave a message with detailed information [__] Leave message with call back number only

Work Phone number: _____
[__] OK to leave a message with detailed information [__] Leave message with call back number only

Email Address: _____ [__] OK to email at the address provided

Mailing Address: **Street:** _____

City: _____ **State:** _____ **Zip**: _____

PLEASE COMPLETE BACK SIDE >>>>

The HIPAA Privacy rule requires healthcare providers to make reasonable steps to limit the use or disclosure of and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services, or for its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.

2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. If you request it, a copy of the information described in this form can be obtained at the front desk.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____	_____	_____
Name of Patient (PRINTED)	Signature of Patient	Date