

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND RECORD OF DISCLOSURE

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I understand that as part of my health care, Seton Family of Doctors originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans my future care or treatment.

I understand that as part of Seton Family of Doctors treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the Seton Family of Doctors in writing.

Patient/ Parent Signature _____ Date _____

Print Name _____ Birth date of patient _____

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

If we need to reach you regarding test results between 8-5, M-F, how may we reach you? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Home phone _____ | <input type="checkbox"/> Work phone _____ |
| <input type="checkbox"/> Leave a message with detailed information | <input type="checkbox"/> Leave a message with detailed information |
| <input type="checkbox"/> Leave a message with call back number only | <input type="checkbox"/> Leave a message with call back number only |
| <input type="checkbox"/> Cell phone _____ | <input type="checkbox"/> Written communication |
| <input type="checkbox"/> Leave a message with detailed information | <input type="checkbox"/> Mail to my home address |
| <input type="checkbox"/> Leave a message with call back number only | |

Should we need to reach you for an emergency, which number is best? (Please Circle)

Home Cell Work Other _____

Do we have your permission to send you test results via secure encrypted email? (please circle one) Yes No

Email address: _____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices

I certify that I have received and read a copy of the Patient Information Privacy Policy.

Signature of Patient/Legal Guardian _____ Date _____

(To be completed if patient refuses to sign acknowledgement)

Date _____ Name of person providing notice _____