HIPAA and Use of Protected Health Information

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES
I acknowledge by signing below that I have received or have been given the opportunity to receive and review a copy of the Vitae Family Care Clinic's Notice of Privacy Practices.

PATIENT NAME: _____ _____ _____
(Please Print) Signature of Patient/Guardian Date

Patient confidentiality is a priority at Vitae Family Care Clinic. Therefore, it is important that you provide us with the following information to ensure your privacy.

AUTHORIZED METHODS OF COMMUNICATION (will be used only if marked)

☐ May Call or leave detailed message on

□ Home phone: #_____

□ Cell phone: # _____

□ Work phone: #_____

□ I authorize text message appointment reminders for each of my appointments on my above listed cell phone

AUTHORIZATION TO DISCLOSE PHI (Protected Health Information)

Please list any family members (**including spouse),** or other designated individuals authorized to receive information regarding your health as deemed necessary (i.e., appointment information, test results, medical status, billing information, etc.)

Name _____ Relationship_____ Phone_____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Signature _ _____ Date _____
(If patient is a minor, then a parent or legal guardian must sign)

☐ **NO AUTHORIZATION**
You have the right to revoke the above disclosure authorization at any time by giving written dated notice.

If you authorize contact and response through e-mail, initial here_____

E-mail address:_____
*Please be aware, E-mail may not be HIPAA compliant.