

**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/Gardian 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ NO AUTHORIZATION** .

You have the right to revoke the above disclosure authorization at any time by giving written dated notice.

Signature \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (If patient is a minor, then a parent or legal guardian must sign)

If you authorize contact and response through e-mail, initial here\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please be aware, E-mail may not be HIPAA compliant.

Form Revised 01/19