Healthcare 2000, LLC

2019

Acknowledgement of receipt of HIPAA Notice of Privacy Practices

By signing this document, I acknowledge that I have read and / or received a copy of the Healthcare 2000, LLC HIPAA Notice of Privacy Practices.

_______________________________________ ______________________________________ ______/____/______

Printed Name Patient Signature Date

Date Acknowledgement received __________/_______/__________

Reason Acknowledgement not obtained:____

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request that confidential communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of the individual home.

I wish to be contacted in the following manner: (check all that apply)

Home Telephone _____________________________

- OK to leave a message
- Leave a message with call back number only

Work Telephone _____________________________

- OK to leave message w/ detailed info
- Leave message with call back # only

Cell / Other Phone ___________________________

- OK to leave detailed message
- Leave message w/ call back number only

Written communication

- ☐ OK to mail to my home address
- ☐ OK to mail to work/office address
- ☐ OK to fax to this # ____________________

Persons authorized to receive information

___________________ relationship

___________________relationship

___________________relationship

_____ **I do not wish to share information with anyone**

_______________________________________ _______________________________ _______________________

Printed Name **Patient Signature** **Date**

______________________________________ _________________________

Witness Signature **Patient Date of Birth**