Acknowledgment of Privacy Practice Policy

Coal Creek Family Medicine wants to assure you that your protected health information is secure with us. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to provide you with a *Notice of Privacy Practices.* The *Notice of Privacy Practices* contains information about how we will insure your information remains private and under what circumstances protected health information about you may be disclosed by us. Please review the notice carefully.

Notice of Privacy Practices Patient Acknowledgment

I, ____________________________________, understand that under The Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have a certain right to privacy in regards to my protected health information. I have received the *Notice of Privacy Practices.* I also understand Coal Creek Family Medicine reserves the right to change the terms of its *Notice of Privacy Practices* and will provide me with a copy of the amended *Notice of Privacy Practices* upon my request.

Signature: _______________________________________ ***Printed Name:*** ________________________________
(Signature of Patient or Guardian if Patient is a Minor) (Printed Name of Guardian if a Minor)

Patient Date of Birth: _______________ ***Relationship to Patient:*** _________________ ***Today's Date:*** _______________

Confidential Communication Authorization

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request the method and location for which we communicate confidential information to you. In order to protect the privacy and confidentiality of your information, please complete the following to indicate your preferences for contact and disclosure of confidential information (check all that apply).

1. Detailed information may be disclosed to the following individual(s):

Name: ___________________________________ **Relationship**: ________________________________

Name: ___________________________________ **Relationship**: ________________________________

Name: ___________________________________ **Relationship**: ________________________________

2. Detailed information may be left on the following voice mail system(s). Please check all that apply:

Patient Home Telephone: ________________________________
(Home Phone Number)

Patient Cellular Telephone: ______________________________
(Cell Phone Number)

Patient Work Telephone: ________________________________
(Work Phone Number)

Additional comments or requests regarding confidential messages:

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I understand that authorizing the disclosure of my health information is voluntary. Furthermore, I understand I have the right to revoke this communication authorization at any time. Revocation of this authorization must be done in writing and presented to Coal Creek Family Medicine. Unless otherwise revoked, this authorization is valid for six years from the date of signing.

Signature of patient or legal representative: _______________________________________ ***Date:***__________________