Tri-City Family Care

Jeramiah Walker APRN-CNP | Board Certified Family Nurse Practitioner

NOTICE OF RECEIPT OF PRIVACY NOTICE

Patient Name (Please Print) _____ Date of Birth _____

Patient Initial _____ I have been given a copy of the TRI-CITY FAMILY CARE Privacy Notice, and understand that I may request a copy of this notice at any time.

USE AND DISCLOSURE AGREEMENT

You have the right to restrict or limit the personal health information we disclose about you to someone else, and to specify the way in which we communicate with you about your medical issues.

Please indicate your preference below:

The following people may receive information about me: **OR** ☐ I do **NOT** want you to speak with anyone else about my health issues.

NAME	RELATIONSHIP

AUTHORIZATION TO LEAVE VOICE AND EMAIL MESSAGES

☐ Yes, TRI-CITY FAMILY CARE **MAY** leave a message on my answering machine/voice mail regarding my Protected Health Information.

☐ No, TRI-CITY FAMILY CARE **MAY NOT** leave a message on my answering machine/voice mail regarding my Protected Health Information.

☐ Yes, TRI-CITY FAMILY CARE **MAY** email me a message regarding my Protected Health Information.

☐ No, TRI-CITY FAMILY CARE **MAY NOT** email me a message regarding my Protected Health Information.

Please specify your preferred method of contact:

Phone: _____ Email: _____

I understand that if I change my mind about any of the information on this form, I must contact Tri-City Family Care to revoke this form in its entirety, or to complete a new form. Otherwise, this form will remain in effect for a period of two years.

Patient Signature _____ Today's Date _____