**Acknowledgement of receipt of Privacy notice and HIPAA**

By signing below, I acknowledge that I have either read online OR been provided a copy of the HIPAA Privacy Notice AND the Notice of Privacy Practices for Oldsmar Rheumatology and have therefore been advised of how my health information is used and or disclosed, and how I may obtain access to and control this information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient signature Patient name Date

**Patient record of Disclosures/Communications**

In general, the HIPPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The information is also provided the right to request Confidential communications or that a communication of health information is made by alternative means.

I can be contacted in the following manner (check all that applies):

At home:

Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_Ok to leave message reminding of appointment on voicemail

\_\_\_\_\_\_\_\_\_Ok to leave detailed message requesting call back

By personal cellphone:

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_ Ok to leave message with a reminder of appointment on voicemenail

\_\_\_\_\_\_\_\_\_\_ Ok to leave text reminder of appointment

\_\_\_\_\_\_\_\_\_\_ OK to

Is there any other route to reach you other than above (including email, work), and if so please detail:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization to speak with others concerning my personal health information:

\_\_\_Family If so, whom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Friends If so, whom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify anyone who you DO NOT wish us to disclose information to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name Date of birth