PATIENT HIPAA ACKNOWLEDGEMENT & DESIGNATION DISCLOURSE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below, I acknowledge that **Neurovations Clinic** has provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

_____	_____	_____
Name of Patient *(Print)*	Signature of Patient/Parent/Guardian	Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In the case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name :_____ Date of birth: _____Phone:_____

Print Name :_____ Date of birth: _____Phone:_____

Print Name :_____ Date of birth: _____Phone:_____

I, _____, acting on behalf of my minor son/daughter _____,

Parent/Guardian (print) **Name of Patient**

as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records.

III. Request to Receive Confidential Communications by Alternative Means: I understand that as part of my health care and treatment that Neurovations Clinic may need to reach me by phone. As provided by Privacy Rule Section 164.522(b),

( ) **I DO** hereby authorize and request that the Practice make all communications to me by the alternative means that I have listed below regarding instructions/procedures, clinical test results, billing and/or appointment needs, etc.

Home/Cell Telephone Number: **Email Communication:**

_____ _____

_____OK to leave message with detailed information

_____OK to e-mail to address listed

_____ _____ _____

Name of Patient *(Print)* Patient Signature Date

( ) **I DO NOT** authorize Neurovations Clinic to contact me to leave a message on my home or cell phone regarding communication of my health care/treatment such as instructions for procedures, clinical test results, billing and/or appointment needs, etc

I understand that by selecting this option it may result in delayed communication of pertinent treatment information such as medication changes, appointment confirmations, billing communications or clinical call backs. I understand that I will be responsible to make appointments to obtain this information.

If you have any questions regarding this notice or any of our office policies, please contact the Practice Administrator at 321-285-2369 or 321-9721079 Thank you.