Arthritis Center: Notice of Privacy Practices Acknowledgement

Arthritis Center will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization.

Patient Full Name: _____ Date of Birth:_____

If there have been no changes to your address, email, or phone number please initial here. ____

Patient Address:	City:	State:	Zip:
E-mail address:			
Home Phone:	Cell Phone:	Work Phone:	
Primary Care Physician	PCP Phone:		

Record of Disclosure

HIPAA privacy rules give individuals the right to request restrictions on disclosure of their protected health information (PHI). Individuals are also provided the right to request confidential communication of PHI be given or prohibited by alternative means, such as, sending correspondence to the individual's office or cell phone instead of the individual's home telephone.

Please check all methods of phone communications that you are permitting disclosure of PHI:

Home Phone: ☐ Leave Message with Detailed Information ☐ Leave Message with call back number only

Cell Phone: ☐ Leave Message with Detailed Information ☐ Leave Message with call back number only

Consent to consult with your other HCP: ☐ Yes ☐ No
(Health Care Providers)

Written Communication: Note address(es) that we have permission to mail Protected Health Information (PHI)

Address: (**If address is same as above initial here**)	City:	State:	Zip:

I give consent to Arthritis Center to discuss or release detail of my medical care, including test results, medications, appointments, etc. to persons below:

Name:	Phone Number:	Relationship:
Name:	Phone Number:	Relationship:

Emergency Contact – Person to call in case of emergency.

Name:	Phone Number:	Relationship:

Authorization to Release Medical Information and Pay Benefits consent for Treatment/Privacy Notice Acknowledgement

I hereby authorize the release of any medical information necessary to bill my insurer and process claims, and I authorize payment of medical benefits be made to Arthritis Center.

Signature of Patient/ Parent or Legal Guardian: _____ Date:_____

Front Desk Initials_____