

**HIPAA Form**

Name of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices and Shared Electronic Medical Record:**

Federal and State law allows us to use and disclose our patients’ protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared electronic Medical Record that allows both our physicians and staff and certain members of the participating physicians of John Muir health and their staff’s access to our patients’ health information. The purpose for this access is to expedite the referral of patients within the John Muir Health system and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the John Muir Health system only with the patient’s expressed authorization or as otherwise specifically permitted or required by law. I hereby acknowledge that I am aware that a copy of this medical practice’s Notice of Privacy Practices is available to me in the office and a copy of any amended Notice of Privacy Practices will be available at each appointment. We encourage you to read it in full. I also authorize New Medical to release all medical information necessary to any hospital, specialist, lab or insurance company acting on my behalf concerning: advice, care, treatment, any services including drug, alcohol or mental health treatment information for purposes related to the administration of billing and claims.

Signed: Patient or Guardian: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not signed by the patient, please indicate relationship:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or guardian of minor patient Telephone:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian or conservator of an incompetent patient:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_