NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT AUTHORIZATION FOR USE/DISCLOSE OF PHI (Protected Health Information)

Patient Name:_____Date of Birth:_____

Acknowledgement of Privacy Notice

I have reviewed the Bucyrus Internal Medicine's, Inc. Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my PHI (Protected Health Information) that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI at, or controlled by, this practice. I understand I can obtain a copy of Bucyrus Internal Medicine's, Inc. Notice of Privacy on request.

Authorization for Use/Disclosure of Protected Health Information (PHI)

I authorize the use and disclosure of all health information for the purpose of treatment, payment and Health Care Operations. I authorize Bucyrus Internal Medicine, Inc, Dr. Roy Harris, DO, FACOI and office staff to use these disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that any revocation does not apply to disclosures or use of PHI that have occurred prior to my revocation. I give consent to Bucyrus Internal Medicine to use On Call Data to review my Medications.
In addition, I authorize disclosure of my PHI to the following individual(s):

_____
_____
_____

List any person(s) that you are allowing this office to communicate with regarding your PHI

Patient Manner of Contact

In general the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that verbal request is an acceptable authorization for the use of any alternate contact method, number and/or location as well as to change in the manner listed below (i.e. if patient leaves message with contact number and/or location other than listed below). I understand that this practice calls to confirm appointments at the number I give.
** I wish to be contacted in the following manner:
_____NO RESTRICTION (okay to contact home and/or work and leave detailed message)
_____Restricted method of contact:
_____Home ONLY - Message to return call to Dr. Harris's office
_____Work ONLY - Message to return call to Dr. Harris's office
_____Other_____
I understand that by signing this form I am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.

Signature_____Date_____
Relationship to patient, if signed by a personal representative, i.e. parent, legal guardian, etc.:
Relationship_____Date_____

Office Signature_____Date_____