FARMINGDALE FAMILY PRACTICE

ACKNOWLEDGMENT OF HIPPA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

I. **Acknowledgment of Practice's Notice of HIPAA Privacy:**
I have read a copy of the Notice of HIPAA Privacy for the Physician Practice.

_______________ _______________ _______________ _______________
Name of Patient | Date of Birth | Signature of Patient/Parent/Guardian | Date

II. **Designation of Certain Relatives, Close Friends and Other Caregivers:**

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person in involved with my health care or payment relating to my health care. In that 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. I wish to be contacted in the following manner (check all that apply):

Telephone, Written, Fax and E-mail Communication

Home Telephone Number:

____

___ OK to leave message with detailed information
___ Leave message with call back numbers only

E-mail:
___ OK to E-mail

Work Telephone Number:

____

___ OK to leave message with detailed information
___ Leave message with call back numbers only

Written Communication:

___ OK to mail to my home address
___ OK to mail to my work/office address

E-mail Address_______________

Fax Communication:

___ OK to fax to this number: _______________
Other: _______________

B. I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _______________ Last four digits of his/her SS Number (Required:) _________
Print Name: _______________ Last four digits of his/her SS Number (Required:) _________
Print Name: _______________ Last four digits of his/her SS Number (Required:) _________

C. The following person(s) are not authorized to receive my Patient Health Information:
Print name: _______________ Print name: _______________

_______________ _______________
Signature of Patient/Parent/Guardian | Date

III. The Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

Date of disclosure request	Disclosed to whom; address/fax number	Description of disclosure	Purpose of disclosure	Dates of service of disclosure	Person completing request	Date completed