HIPPA PRIVACY FORM
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document out good faith effort to obtain that acknowledgment.

You may refuse to sign this acknowledgment

I, _____, have received a copy OR read the explanation of Jenna Dickey, RDAHP's Notice of Privacy Practices.

Signature of Patient and/or Guardian: _____ Date: _____

Relationship to Patient: Self or Other: _____

I, _____, acknowledge and allow Jenna Dickey, RDHAP to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call:

[ ] my home phone [ ] my work phone [ ] my cell phone

_____ _____ _____

If unable to reach me:

[ ] You may leave a detailed message [ ] Please leave me a message asking for a return call OR

[ ] You may e-mail me at _____ OR

[ ] Text me at _____

Signature: _____ Date:_____

Witness: _____ Date: _____