HIPAA FORM

Keeping Your Personal Health Information Private

Patient Name: _____
(Last) (First) (Middle)

Home/daytime contact phone number: _____

May we leave a message with other residents at home? ___Yes ___ No

May we leave a message on your home answering system/voicemail? ___Yes ____ No

To whom may we talk to about your child's medical treatment?

1. Name_____Relationship_____
   Home Phone No._____ Cell No. _____
   Other Phone No. _____
   Is this person an emergency contact also? _____Yes _____ No
   Leave Message on the Cell Phone Voicemail? _____Yes _____No
2. Name_____Relationship_____
   Home Phone No._____ Cell No. _____
   Other Phone No. _____
   Is this person an emergency contact also? _____Yes _____ No
   Leave Message on the Cell Phone Voicemail? _____Yes _____No

If any of the above information changes, it is the Patient/Parent/Legal Guardian's responsibility to contact our office.

Patient/Parent/Legal Guardian Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient/Parent/Legal Guardian Signature _____Date _____