Patient Full Name: _____ Date of Birth: _____
(Please Print)

Privacy Practices Acknowledgement and Receipt

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, this information must be completed and updated annually by the patient or guardian.

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give the Physician Associates group and its providers and employees my permission to discuss freely my condition, treatment or diagnosis with that person present.

(Circle one) YES NO

Notice of Privacy Practice:

By signing below, I acknowledge that I have been provided a copy of this facility's Notice of Privacy Practices Form 3732-3732-PPSI-2061 (Rev. 02/10) for review and a personal copy to keep will be provided upon request.

Signature of Patient or Guardian: _____ **Date:** _____

Release of Personal Health Information (PHI)

This information must be completed and updated every 6 months by the patient or guardian.

This release authorizes the Physician Associates group to discuss medical information regarding my care, condition, treatment or diagnosis with the following:

☐ **Patient Only**

☐ **Spouse (*Specify Name of Spouse):*** _____

☐ **Parent (*Specify Name of Parent(s)*):** _____

☐ **Other *(Please specify)*:** _____

When contacting you with test results such as labs, x-rays, etc., please mark one or all desired:

☐ Home Phone: _____ May we leave a detailed message: **YES / NO**

☐ Work Phone: _____ May we leave a detailed message: **YES / NO**

☐ Cell Phone: _____ May we leave a detailed message: **YES / NO**

Signature of Patient or Guardian: _____ **Date:** _____

Relationship to Patient: _____ (i.e., Self, Parent)