HIPAA
PATIENT ACKNOWLEDGEMENT

DATE: _____

I understand I have certain rights to privacy regarding my protected health information. I understand by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers); Obtaining payment from third party payers (my insurance company (if applicable)).

_____ _____
_____

Please **PRINT** your name Please **SIGN** your name

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

- ☐ First Name Only
- ☐ Proper Sir Name
- ☐ Other _____

I AUTHORIZE INFORMATION ABOUT MY HEALTHCARE BE CONVEYED VIA:

- ☐ CELL PHONE CONFIRMATION
- ☐ HOME PHONE CONFIRMATION
- ☐ TEXT MESSAGE TO MY CELL PHONE
- ☐ EMAIL CONFIRMATION
- ☐ **ANY OF THE ABOVE**

In signing this HIPAA Patient Acknowledgement Form I acknowledge and authorize that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies.