Memorial INTERNAL MEDICINE

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of Memorial Internal Medicine, Notice of Privacy Practices, which sets forth the ways in which my medical record information can be used or disclosed by our organization and which outlines my rights to this information.

Print Name: ______________________________________ Date: _____________________________

Signature of Patient: ____
Or personal representative (parent, guardian, POA)

Witness: ____

HIPAA REQUEST: (Patient – please mark below)

O Call patient at home

O Call patient at work

O Permission to leave message/medical information on answering machine or voicemail

O Permission to leave message/medical information or results with the following family members:

____

For Office Use Only

__________ A good faith effort was made to provide a copy of the Notice of Privacy Practices to this patient and to obtain his/her acknowledgement of the same. The patient __________ accepted;

__________ declined the Notice and refused to sign this acknowledgement for the following reason:

____

Practice Representative: ____

Signature: _______________________________________ Date: ______________________________