ORTHO SPINE AMERICA

# Patient HIPAA Acknowledgment and Designation Disclosure Form

## I. ACKNOWLEDGMENT OF PRACTICE'S HIPAA PRIVACY NOTICE:

By subscribing my name below, I acknowledge that ______________________________ has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so choose) and understand my rights, asked questions regarding my rights, received answers to my satisfaction, and I agree to its terms.

Patient Name ______________________________ Signature ______________________________
**Please Print** **Patient / Parent / Guardian**

Phone ______________________________ Date ______________________________

## II. DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: ______________________ Last four digits of his/her SSN or password (required): _______ Phone: ________________

Print Name: ______________________ Last four digits of his/her SSN or password (required): _______ Phone: ________________

Print Name: ______________________ Last four digits of his/her SSN or password (required): _______ Phone: ________________

I, ______________________________ , acting on behalf of my minor son/daughter ______________________________
**Parent/Guardian (print)** **Name of Patient**

as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records.

## III. REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternativemeans that I have listed below.

**Home / Cell Telephone Number:**

______________________________

- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call back numbers only**

**Written Communication Address:**

______________________________

- ☐ **OK to mail to address listed above**
- ☐ **E-mail me at:** ______________________________

**Work Telephone Number:**

______________________________

- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call back numbers only**

**Fax Communication:**

______________________________

- ☐ **OK to Fax to the number listed above**

**Other:** ______________________________

Patient Name ______________________ Signature ______________________ Date ____________
**Please Print** **Patient / Parent / Guardian**

Witness ______________________ Date ____________