

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I have received on this visit/admission or a previous one, the Notice of Privacy Practices that explains how the facility may use my information. The Notice of Privacy Practices is also available on the SSM Health Care website. As explained in the Notice of Privacy Practices, the facility will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization.

 First Name MI Last Name Date of Birth

 Signature of Patient / Parent or Legal Guardian Date

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST RESTRICTION ON DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI MAY BE MADE BY ALTERNATIVE MEANS SUCH AS: SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE OR CELL PHONE, INSTEAD OF THE INDIVIDUAL'S HOME PHONE.

PLEASE CHECK ALL THAT APPLY
 (Indicate with a "P" primary method of communication)

HOME TELEPHONE #:		WRITTEN COMMUNICATION:		MY CHART:	
<input type="checkbox"/>	LEAVE MESSAGE WITH DETAILED INFORMATION	<input type="checkbox"/>	O.K. TO MAIL TO:	<input type="checkbox"/>	O. K. TO SEND MESSAGE WITH DETAILED INFORMATION
<input type="checkbox"/>	LEAVE MESSAGE WITH CALL BACK NUMBER ONLY	<input type="checkbox"/>	O.K. TO FAX TO:	<input type="checkbox"/>	
WORK TELEPHONE #:		CELL PHONE #:		OTHER (list below):	
<input type="checkbox"/>	LEAVE MESSAGE WITH DETAILED INFORMATION	<input type="checkbox"/>	LEAVE MESSAGE WITH DETAILED INFORMATION	<input type="checkbox"/>	
<input type="checkbox"/>	LEAVE MESSAGE WITH CALL BACK NUMBER ONLY	<input type="checkbox"/>	LEAVE MESSAGE WITH CALL BACK NUMBER ONLY	<input type="checkbox"/>	

I give consent to SSM Medical Group to release/discuss details of my medical care, including test results, medications, appointments, and other information with the persons listed below:

NAME	RELATIONSHIP	PHONE NUMBER

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD

For Office Use: _____
 Entered into system by Date