



RECEIPT OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT RECORD OF DISCLOSURES

PATIENT NAME: _____

DATE OF BIRTH: _____

A) ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of Arroyo Vista Family Medicine' Notice of Privacy Practices, which explains how my personal health and medical information will be used and disclosed.

B) PATIENT RECORD OF DISCLOSURES

In general, the HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. As such, **I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE INDICATE YOUR SELECTION):**

Home Telephone _____

- Leave a voice message with detailed information
- Leave a message with call back number only
- Please **do not** leave a message

Work Telephone _____

- Leave a voice message with detailed information
- Leave a message with call back number only
- Please **do not** leave a message

Mobile Telephone _____

- Leave a voice message with detailed information
- Leave a message with call back number only
- Please **do not** leave a message

Written Communication

- Mail to my home address _____
- Mail to my work address _____
- Please **do not** mail

The following people may have access to my medical information:

- Spouse/Significant Other: _____
- Child: _____
- Child: _____
- Parent: _____
- Other: _____
- Nobody** should have access

C) PRESCRIPTION ORDER PICK-UP AUTHORIZATION:

There may be times when you need a friend or family member to pick up a prescription order from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the prescription, your designee will need to present valid picture identification and sign for the prescription. As such, **I WISH TO DESIGNATE THE FOLLOWING FAMILY MEMBER/FRIEND TO PICK UP AN ORDER ON MY BEHALF**

1) Name: _____

2) Name: _____

By signing below, I certify that I have read and understand the above information and have had any questions answered. My signature also certifies my understanding of and agreement with the above policies. A photocopy of this document is as valid as the original and may receive a copy of this document upon request.

Signature of Patient, Parent, or Legal Guardian

Relationship to Patient

Date

Witness Signature

Title