

Regional Rheumatology Associates, LLP
Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information.

I understand that there may be times that a message that does NOT contain confidential medical information must be left at my home/office when I am not available to receive the message myself.

I consent to have Regional Rheumatology Assoc. leave appointment messages on:

- | | | |
|---|----------|---------|
| * Answering Machine | _____yes | _____no |
| * Office Voice Mail | _____yes | _____no |
| * With Another Person | _____yes | _____no |
| * Send through the Mail | _____yes | _____no |
| * Send via E-mail | _____yes | _____no |
| * Cell phone | _____yes | _____no |
| * Persons Authorized to Communicate With? | | |

I consent to have Regional Rheumatology Assoc leave other medical information on:

- | | | |
|---|----------|---------|
| * Answering Machine | _____yes | _____no |
| * Office Voice Mail | _____yes | _____no |
| * With Another Person | _____yes | _____no |
| * Send through the Mail | _____yes | _____no |
| * Send via E-mail | _____yes | _____no |
| * Cell phone | _____yes | _____no |
| * Persons Authorized to Communicate With? | | |

I further understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature and acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

| | |
|---------|------------------------------|
| Date: | Office Staff Name/Signature: |
| Reason: | |