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** _________________________
  - ☐ Please **do not** leave a message
  - ☐ Leave a message with call back number only
  - ☐ Leave a voice message with detailed information
- ☐ **Work Telephone** __________________________
  - ☐ Please **do not** leave a message
  - ☐ Leave a message with call back number only
  - ☐ Leave a voice message with detailed information
- ☐ **Mobile Telephone** ________________________
  - ☐ Please **do not** leave a message
  - ☐ Leave a message with call back number only
  - ☐ Leave a voice message with detailed information
  - ☐ Send a text message **without** detailed health information
- ☐ **Written Communication**
  - ☐ Please **do not** mail
  - ☐ Mail to my home address ___________________
  - ☐ Mail to my work address ____________________

The following people may have access to my medical information:
- ☐ **Nobody** should have access
- ☐ Spouse/Significant Other:___________________
- ☐ Child:___________________________________
- ☐ Child:___________________________________
- ☐ Parent:__________________________________
- ☐ Other: __________________________________

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.

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Signature of Patient, Parent, or Legal Guardian **Relationship to Patient** **Date**

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Witness Signature **Title**