Premier Family Medicine, LLC

Patient Name:_______________________

DOB: ________________

Last 4-digits of SSN: __________________

Acknowledgement of Receipt
of Notice of Privacy Practices
and
Express Consent to Communication

HIPAA & Your Protected Health Information
Use and disclosure of Protected Health Information (PHI, aka Medical Records) in regulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, we are required to give patients our Notice of Privacy Practices for PHI. HIPAA also requires that adult patients specify to whom (if anybody) we may release their PHI.

Patient Instructions for PHI Communication
I authorize my doctor or staff to leave messages including certain medical information. By selecting "YES" below, you hereby give express consent for Premier Family Medicine, its employees and agents to contact you at the phone numbers listed for the purpose of communicating with you about your interaction with our practice; including lab and test results and healthcare information. You may cancel this consent at any time by completing a new form.

☐NO Do Not leave messages on my answering machine or voice mail. I prefer that my doctor or staff speak to me personally regarding any medical information.

☐YES May leave messages on my voice mail at *[phone#]*: ___________________________________

☐YES May share information with the following individuals *[write name(s) and relationship]*:

Name:	Relationship:

Express Consent to Communication
In addition to the above listed Authorization or Denial of Authorization, as a patient or representative of a patient, you hereby authorize Premier Family Medicine, our employees and agents to contact you and leave messages about appointment reminders and billing & collections. This consent also authorizes such communications to be sent by automated dialers and messaging equipment.

Acknowledgement
I acknowledge that I have read the above paragraphs, that Premier Family Medicine has made available to me a written copy of its Notice of Privacy Practices for me to read on behalf of myself, my family and/or my dependent, and that I give Express Consent to Communication.

Authorization of the Release of PHI
I attest that I am the patient, the legal guardian, or Power of Attorney of the patient and authorize the release of Protected Health Information to the Individual(s) listed above for the next 18 months. I understand that I may rescind this authorization at any time by completing a new form.

PATIENT/GUARANTOR Signature:____Date:__________________

To be completed by Premier Family Medicine, LLC: We have made a good faith effort to provide the above named patient with a copy of our Notice of Privacy Practices, but were not successful for the following reasons:

☐ Patient Refused ☐ Other ____

________________________ EMPLOYEE Name ____________ Title ________________________ EMPLOYEE Signature ____________ Date

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