Dr. Evan B. Kelner, D.P.M.

ACKNOWLEDGEMENT OF PRACTICE OF HIPAA PRIVACY FORM

____ ____

PATIENT NAME DATE OF BIRTH

____ ____

SIGNATURE DATE

DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS OR OTHER CARE GIVERS:
I AGREE THAT THE PRACTICE MAY DISCLOSE CERTAIN INFORMATION OF MY HEALTH RECORD TO A FAMILY MEMBER, CLOSE FRIEND OR OTHER CARE GIVER INVOLVED WITH MY HEALTH CARE. IN THAT CASE, THE PHYSICIAN'S PRACTICE WILL DISCLOSE ONLY INFORMATION THAT IS DIRECTLY RELEVANT TO THE PERSON'S INVOLVEMENT WITH MY HEALTH CARE. I, ALSO, AGREE THAT THE PRACTICE CAN DISCLOSE INFORMATION TO MY MEDICAL INSURANCE TO OBTAIN PAYMENT FOR SERVICES RENDERED.

THE FOLLOWING PERSON(S) IS/ARE NOT AUTHORIZED TO RECEIVE MY PATIENT HEALTH INFORMATION:

____ ____

NAME NAME

____

SIGNATURE OF PATIENT/PARENT/GUARDIAN

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

____ OK TO LEAVE MESSAGE WITH DETAILED INFORMATION

____OK TO LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

____OK TO MAIL TO HOME ADDRESS

THE PRIVACY RULE GENERALLY REQUIRES HEALTHCARE PROVIDERS TO TAKE REASONABLE STEPS TO LIMIT THE USE OF, AND REQUESTS FOR PATIENT HEALTH INFORMATION TO THE MINIMUM NECESSARY TO ACCOMPLISH THE INTENDED PURPOSE. THESE PROVISIONS DO NOT APPLY TO THE USES OF DISCLOSURES MADE PURSUANT TO AN AUTHORIZATION REQUESTED BY THE PATIENT/PARENT/GUARDIAN. HEALTHCARE ENTITIES MUST KEEP A RECORD OF PATIENT HEALTH INFORMATION DISCLOSURES. THE PATIENT WILL BE PROVIDED WITH AN ADEQUATE RECORD OF ANY DISCLOSURE THAT WILL BE GIVEN WITHOUT CONSENT IN ADVANCE.