

Acknowledgement of Privacy Practices

I have reviewed PACN's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

Print Name

Signature

Patient Record Of Disclosures

In general, the HIPAA privacy rules give 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.

Please provide your preferred contact phone # for medical follow-up:

(_____)_____

Please check all that apply:

- Call from a confidential/private line; Do not identify PACN on caller ID
- Contact me via text message (will allow for appointment reminders/cancellations)
- Contact me via email (will allow patient portal access to test results/US summary)
- I do not wish to receive postal mail at my home address (excludes correspondence due to State reported illness/ abuse or HIPAA violations)

The following people may have access to my medical information:

NOBODY SHOULD HAVE ACCESS

Name: _____

Name: _____

Relationship to you: _____

Relationship to you: _____

Phone Number: _____

Phone Number: _____

Name: _____

Name: _____

Relationship to you: _____

Relationship to you: _____

Phone Number: _____

Phone Number: _____

Client Signature

Today's Date

Date of Birth