CHURCHLAND FAMILY MEDICINE, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction,
By signing this form you acknowledge that you were provided a copy of Churchland Family Medicine's Notice of Privacy Practices.

Churchland Family Medicine, P.C. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996, also known as HIPPA

The patient understands that;
*Protected health information may be disclosed or used for treatment, payment or health care operations.
*Churchland Family Medicine has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
*Churchland Family Medicine reserves the right to change the Notice of Privacy Practices
*You have the right to restrict the use of your information but Churchland Family Medicine does not have to agree to those restrictions.
*You may revoke this Consent in writing at any time and all future disclosures will then cease.

Family and Friends
It is the office policy of Churchland Family Medicine, P.C. not to release confidential medical information regarding your treatment to family members or friends, except for parent/legal guardian, other persons authorized by the patient, or as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume that that person is entitled to receive information regarding your treatment), in emergency situations, or other as permitted by the Health Insurance Portability and Accountability Act (HIPPA).

If you anticipate that you will need or want your medical information (including but not limited to appointment times, prescription and payment) to be provided to family members, friends or caretakers, please indicate below. By signing below, you authorize the following people to receive detailed information regarding your treatment or care; (If you wish to add names later on, please confirm this in writing.)

SPOUSE: _____

PARENT: _____

OTHER:_____

MAY WE LEAVE A DETAILED MESSAGE ON YOUR HOME ANSWERING MACHINE? YES____ N0____

Alternative Communications; You are also entitled to specify alternative, reasonable means of communication.

I hereby request the following means of contact only; _____

Signature of patient OR person with power of attorney: _____

Printed name of party above: _____

Date:_____ Patient DOB:_____

Revised 1/1/14