PATIENT RECORD OF DISCLOSURES/ PRIVACY POLICY ACKNOWLEDGEMENT FORM
Knox Orthopaedics

In general, the HIP AA 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 communication or that a communication of (PHI) be made by alternative means, such as sending medical correspondence to the individuals office instead of the individuals home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER

Home Telephone _____
☐ OK to leave a message with detailed information
☐ Leave a message with a call back number only

Electronic/Home Communication
☐ OK to send to my Email address
Email Address:_____
☐ OK to send to my Home address

Work Telephone _____
☐ OK to leave a message with detailed information
☐ Leave call back number only
☐ Other _____

Cell _____
☐ OK to leave a message with detailed information
☐ Leave a message with a call back number only

Please list below any person(s) who might call and make appointments for you, pick up prescriptions or medical information about you that you give us permission to disclose your information to. (example: Spouse, child, guardian, parent, friend, etc.)

NAME	RELATIONSHIP
(1)	
(2)	
(3)	

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to an authorization requested by the individual. Note:

Uses and disclosures for healthcare operations (IPO) may be permitted without prior consent in emergency or other instances listed in this Notice of Privacy Practices.

By supplying my borne phone number, mobile phone number, email address and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and any other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

I have received the **Notice of Privacy Practices** and/or I have been provided an opportunity to review it. I have also stated how I wish to be contacted and who I wish to disclose information to above.

_____ _____ _____
PATIENT PRINTED NAME PATIENT SIGNATURE DATE

If not patient, please state' relationship to patient:_____
RELATIONSHIP

RESTRICT DISCLOSURE OF PROTECTED HEALTH INFORMATION

LIST NAME	RELATIONSHIP