Lake Kiowa Medical Clinic

## Acknowledgement of review of Notice of Privacy Practices (HIPPA)

I _____ (patient name) ____/____/_____ (DOB) have been given the opportunity to review this office'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.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

### COMMUNICATIONS AUTHORIZATION AND RELEASE OF INFORMATION

1. **DO WE HAVE PERMISSION TO:** leave a message concerning Laboratory, X-ray or other diagnostic results on: Home phone: Yes / No Cell phone: Yes / No

2. **MAY WE CONTACT YOU AT WORK REGARDING:** Appointments, lab results or other health care issues? Yes / No

3. **PLEASE LIST BELOW WHO WE MAY DISCUSS HEALTH CARE ISSUES:**

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

4. **PERSON WHO IS RESPONSIBLE OR GUARDIAN FOR THE HEALTH OF AGED PARENT, DISABLED INDIVIDUAL OR CHILD:**

Name: _____ How Authorized: _____

5. **PERSON WHO MAY BE PRESENT WHILE AN EXAMINATION, DISCUSSION, OR OTHER HEALTH CARE PROCEDURE:**

Name: _____ Relationship: _____

6. **PERSON WHO MAY PICK UP PRESCRIPTIONS, EQUIPMENT, OR OTHER HEALTH CARE INFORMATION:**

Name: _____ Relationship: _____

_____ _____

**Signature of Patient or Personal Representative** **Date**