PATIENT HIPAA ACKNOWLEDGEMENT, DESIGNATION DISCLOSURE, RIGHTS TO REQUEST PRIVACY PROTECTION FOR PROTECTED HEALTH INFORMATION AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FORMS.

I. HIPAA Acknowledgement (*Notice of Privacy Practices*):

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

_____	_____	_____	_____
Name of Patient	**Date of Birth**	**Signature of Patient/Parent/Guardian**	**Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

There are times we are asked to give family members or other representatives, information on test results and other health information, especially if you will not be available to receive such information. If you would like for us to give out information regarding your treatment and/or test results to your designated representative, please fill out their name, relationship to you and contact phone number. Please designate which type of information each person may receive by checking the items we may release and any items we should not disclose.

Definitions:

All Information: Any and All information we have in your file.
Appointments Only: Only information related to appointment dates and times.
STDs/HIV: Information related to Sexually transmitted disease including HIV/ AIDS, HSV, HPV, Syphilis, Gonorrhea, Chlamydia, abnormal PAPs, Vaginitis, Trichomonas etc.
Other Labs: Information related to any Labs other than STDs/HIV, eg. CBC, CMP etc.
Other Tests: Any information related to Diagnostic tests including but not limited to X-ray,EKG, ECHO, CT scans, MRI, Ultrasound, stress test etc.
Mental Health: Information related to mental health diagnosis, eg. Depression, anxiety, ADHD,OCD etc.

I agree that Nirog Health Center may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, Nirog Health Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care as listed below:

Relationship	Name of Representative	Phone # of Representative	Type of information which may be releases				
			All Info	Appts Only	STDs/ HIV	Other Labs/ tests	Mental Health

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Nirog Health Center make all communications to me by:

Cell Phone Number: _____
OK to leave message with detailed information / Leave message with call back numbers only

Home Telephone Number: _____
OK to leave message with detailed information / Leave message with call back numbers only

Work Telephone Number: _____
OK to leave message with detailed information / Leave message with call back numbers only

Written Communication Address:
_____
OK to mail to address listed above

Email me at: _____

Name of Patient (Print): _____

Signature Date Witness: _____Date:_____

IV. Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to **Nirog Health Center,** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Nirog Health Center,** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Nirog Health Center,** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Nirog Health Center.**

With this consent, **Nirog Health Center** may call my home and/or other alternative number and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance or payment items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Nirog Health Center** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

I have the right to request that **Nirog Health Center** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Nirog Health Center** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Nirog Health Center** may decline to provide treatment to me..

Print Patient’s Name	Signature of Patient or Legal Guardian	Date