NINTH STREET INTERNAL MEDICINE ASSOCIATES
ACKNOWLEDGEMENT OF
HEALTH INFORMATION PRACTICES

I, _____ acknowledge receiving a copy of the
Name
office's privacy notice. I have read it and I understand how my private health information will be used, and who will have access to it. I also understand that when the office discloses health information for any purpose outside of treatment, payment, and health care operations, it will require my signature in the form of a formal authorization.

Please list the family members or other persons with whom we may discuss your general medical condition:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Please list the additional family members or other persons with whom we may discuss your medical condition **ONLY IN AN EMERGENCY:**

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Please indicate if you want all correspondence from this office sent to your home address

YES_____ NO_____

Alternate address if not home:_____

_____

Please indicate the telephone # you wish us to use to contact you _____
May we leave a message on an answering machine/voice mail? YES_____ NO_____

Date_____ Signature_____

Please note: We are only allowed to communicate about you with individuals listed on this sheet, so please list all appropriate names and tell us if you need to update the list.