JSAPA
HIPPA - PRIVACY NOTICE

Patient Name: ______________________________________Date of Birth:__________________

Social Security Number: ____

Address: ____

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Phone Number: ____________________________

Acknowledgment of Receipt of Privacy Notice for JSAPA

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____________________________________ ___________________________________

Signature of Patient or Legal Representative Date

Request for an *Exception* to the disclosure rules regarding the Release of Protected Health Information (PHI)

❑ Exception for Disclosure (Individuals or means where by P.H.I. may be released)

I authorize the following people to be involved in my care. This consent for disclosure includes both health and financial information as it relates to my care.

Individual's Name (Please Print) *Relationship to Patient*

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Over

Request for *Restriction* regarding the Release of Protected Health Information (PHI)

☐ Restriction for the disclosure of Protected Health Information (PHI)
(Individuals or means where by P.H.I. cannot be disclosed.)

Please be specific in your request:

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______________________________ ______________________________
Signature of Patient or Legal Representative Date of Request

For Practice Use Only:

______________________________ ______________________________
Signature of Employee receiving request Date Received

Request for restriction/exception has been ☐ Approved ☐ Denied

Reason for denial: ____

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______________________________ ______________________________
Signature of Privacy Officer Date