PATIENT HIPAA ACKNOWLEDGEMENT DISCLOSURE FORM

DR. PHILIP N. RING D.D.S., PC

I. Acknowledgement of Practice's *Notice of Privacy Practices*:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its term.

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice 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, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____**Relation:**_____
Print Name: _____**Relation:**_____
Print Name: _____**Relation:**_____

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Best Contact Number:

_____
_____OK to leave message with detailed information

Written Communication Address:

_____
_____OK to mail to address listed above

Work Telephone Number:

_____
_____OK to leave message with detailed information

Email Communication:

_____
_____OK to email the address listed

_____
Name of Patient (Print)

_____
Signature and Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date_____Initials_____ Reason_____