HIPAA Acknowledgement & Confidential Communication Request

Date: _________________ **Patient DOB:** ____________

ACKNOWLEDGEMENT

I acknowledge receipt and reviewed the Pueblo Community Health Center Notice of Privacy Practices (please sign below). I would like to receive a copy of any amended Notice of Privacy Practices by email: ___Yes ____No
If yes, please provide email address: _______________________________________

COMMUNICATION

I also would like Pueblo Community Health Center to follow these instructions when contacting me regarding my health care (please mark all that apply):

At day phone number listed (preferred contact number):

Leave messages on my answering machine/voice mail __ Allow ___ Not allow
Leave messages with any other person __ Allow ___ Not allow

At alternate phone number: (_____) ______-_________

Leave messages and tell them who is calling if asked __ Allow ___ Not allow
Leave messages on alternate phone voice mail or answering machine __ Allow ___ Not allow

---

Signature of Patient: ____ Date __________________

Print Name: ____

If not signed by patient (or plan member), please complete section below and indicate your relationship:

____ Parent/Guardian of minor patient.
Mother's Name: ________________________ Father's Name: _________________________
____ Beneficiary or personal representative of deceased patient (Copy of court order needed)
____ Guardian or Conservator of an incompetent person (Copy of court order needed)
____ Other (specify) ____

Privacy Practice Acknowledgement must be signed before initial visit to Pueblo Community Health Center. You may end or change "Communication" section in this form at any time by filling out a new form. All previous "HIPAA Acknowledgement & Confidential Communication Request" forms will be void.

Staff Initials: _________ Dept: ______________________________

Date sent to Med Rec: ___________ Med Rec Clerk Initials: _____________ Scanned Date: ______________

HIPAA Acknowledgement & Confidential Communication Request

Date: ________________ **Patient DOB:** ____________

AUTHORIZATION

I, ____, give my permission to Pueblo Community Health Center and/or any staff member of Pueblo Community Health Center, to discuss my health care with the individuals noted below who may, from time-to-time, help me receive and pay for health care. This may include, but is not limited to, attending my appointments, helping me follow treatment recommendations, picking up medicines, helping me understand my test results, helping me understand and make payments for health care

Name____ Relationship___________________ Phone #______________

Name____ Relationship___________________ Phone #______________

RESTRICTIONS

The following people shall not be allowed access to my Personal Health Information:

Name____ Relationship___________________

Name____ Relationship___________________

Signature: ____ Date __________________

Print Name: ____ Date of Birth ____________

If not signed by patient (or plan member), please complete section below and indicate your relationship:

____ Parent/Guardian of minor patient.
Mother's Name: ___________________________ Father's Name: ___________________________
____ Beneficiary or personal representative of deceased patient (Copy of court order needed)
____ Guardian or Conservator of an incompetent person (Copy of court order needed)
____ Other (specify) ____

You may end or change the directions in this form at any time by filling out a new form. All previous "HIPAA Acknowledgement & Confidential Communication Request" forms will be void.

Staff Initials: _________ Dept: ______________________________

Date sent to Med Rec: ___________ Med Rec Clerk Initials: _____________ Scanned Date: ______________