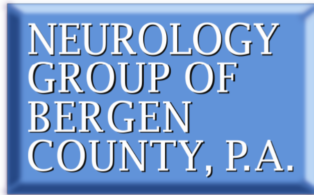

HIPAA

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Patient's Name:___________________________________ has received a copy of the Neurology Group of Bergen County's Notice of Privacy Practices.

____ _____________________
Signature of Patient Date

____ _____________________
Signature of Parent or Legal Guardian Relationship to Patient

____ _____________________
Print Name of Parent or Legal Guardian Date

Patient Authorization For Use And Disclosure of Protected Health Information

I wish to be contacted at the following number :_________________________________
(You may be left a detailed message concerning your appointment or other details of your medical care at this number.)
I give permission to have medical/appointment/billing information left on my:

Home Answering Machine Yes No **Cell Phone Yes No**

Work Phone Yes No **E-mailed to me Yes No**

I give permission for the individual(s) listed below to speak with your office or to leave information regarding medical/appointment/billing :

Name(s) & Relationship(s) **Phone Number(s)**

____ _______________________________

____ _______________________________

____ _______________________________

HIPAA privacy rules give you the right to request a restriction of your protected health information. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule.

By signing this authorization, you are providing us with permission to contact you by E-mail. If you do not authorize us to communicate with you in this manner, please check "No." ☐ **No**

____ ____________________ _______________
Signature of Patient or Legal Guardian **Relationship to Patient** **Date**

This authorization will expire on________________________________

2/6/17 rev cb