PATIENT PRIVACY POLICY ACKNOWLEDGEMENT FORM

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information (PHI). In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their PHI. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at (423) 622-2494.

Patient Name _____

☐ Home Telephone
- ☐ O.K to leave message with detailed information
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ O.K to mail to my home
- ☐ O.K to mail to my work
- O.K to fax to this number

☐ Work Telephone
- ☐ O.K to leave message with detailed information
- ☐ Leave message with call back number only

Other _____
_____

Authorization to release Protected Health Information to the individuals/family members

____ I authorize Chattanooga Surgical Oncology & Associated to verbally, or with written consent, release any or all of my PHI to the following individuals

_____
Name Relationship to Patient

_____
Name Relationship to Patient

_____
Name Relationship to Patient

_____
Name Relationship to Patient

____ I do not authorize Chattanooga Surgical Oncology & Associated to release any or all of my PHI to any individual/ family members except as set forth above.

Patient Signature _____ Date _____
Witness _____