

PATIENT PRIVACY POLICY ACKNOWLEDGMENT 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 disclosures 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 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 423-698-0304.

Patient Name: _____

Home Telephone: _____

OK to leave message with detailed information.

Leave message with call-back number only.

Cellular Telephone: _____

OK to leave message with detailed information.

Leave message with call-back number only.

Work Telephone: _____

OK to leave message with detailed information.

Leave message with call-back number only.

Written Communication

OK to mail to my home

OK to mail to my work

OK to fax to this number: _____

Other: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

_____ I authorize the Breast Center of Chattanooga to verbally release any or all 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 the Breast Center of Chattanooga to release any or all of my PHI to any individuals/family members.

Patient Signature: _____ Date: _____

Witness: _____

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Chattanooga, TN 37404
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