



Patient Name

Patient Date of Birth

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Phillips Medical Group, P.C. *Notice of Privacy Policy*, and have been provided an opportunity to review it.

Initial _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (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.

I understand that Phillips Medical Group will take all reasonable steps to ensuring my medical records are kept confidential. I give Phillips Medical Group permission to contact me at the address(es) and phone number(s) provided to them.

Initial _____

INFECTION CONTROL

If any employee of Phillips Medical Group, P.C. or other health care worker is exposed to my blood or other body fluids, I hereby authorize Phillips Medical Group, P.C. to test my blood for Hepatitis B, Hepatitis C, and HIV (the virus that causes AIDS). I understand the tests will be done at the expense of Phillips Medical Group P.C.

Initial _____

RELEASE OF CONFIDENTIAL INFORMATION FOR BILLING PURPOSES

Disclosure of substance abuse, psychiatric treatment, and HIV information is protected by federal and state law. Federal and state law prohibit making any disclosure of confidential information without the consent of the person to whom it pertains, or as otherwise permitted or required by federal or state law. The undersigned hereby authorizes Phillips Medical Group, P.C., and affiliates and any involved physician(s) and/or employees to release to the patient's insurance company or other third party payer, for the purpose of securing payment of insurance benefits, information contained in the patient's medical record regarding the patient's treatment for alcohol or drug abuse, the patient's treatment for mental illness, and the fact that an HIV test was performed on the patient and the patient's HIV test results.

Signature of Patient or Authorized Representative

Print Name

Date

Witness

Date