themehraclinic

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF

PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE

Patient Legal Name: _____ Date of Birth: _____
(Last Name, First Name) (Month/day/year)

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices and Statement of Patient and Family Rights for this healthcare facility.

The HIPAA privacy rule gives individuals, parents or guardians the right to request a restriction on uses and disclosures of their (their child's) protected health information (PHI). See the The Mehra Clinic, PLLC Notice of Privacy Practices.

The individual/parent/guardian is also provided the right to request **confidential** communications of PHI or other sensitive information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST The Mehra Clinic, PLLC MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO THE PATIENT'S HEALTH INFORMATION
(This includes step parents, grandparents and any care takers – PHOTO ID REQUIRED):

I hereby give permission to the person(s) listed below to receive confidential information about the care of the above-named patient.

Printed Name: _____ Relationship to Patient: _____

Contact Phone/Email: _____

Printed Name: _____ Relationship to Patient: _____

Contact Phone/ Email: _____

MY PREFERENCE FOR CONTACT FROM THIS OFFICE REGARDING **MY CHILD'S CARE** IS:

Cell Phone ☐ Home Phone ☐ Work Phone ☐ Any method listed ☐

I AUTHORIZE **INFORMATION ABOUT MY HEALTH, TREATMENT & BILLING INFORMATION** BE CONVEYED VIA:

□ Cell Phone □ Home Phone □ Work Phone □ E-mail □ Any method listed

_____ Date: _____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Printed Name of Patient, Parent, Guardian or Personal Representative

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual, parent, guardian or personal representative.

Note: In an emergency, uses and disclosures of PHI for treatment, payment or healthcare operations may be permitted without prior consent.

Patient Name _____

DOB: _____ MR# _____

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

___It was emergency treatment
___I could not communicate with the patient
___The patient refused to sign
___The patient was unable to sign because
___Other (please describe)

Signature

_____

The Mehra Clinic, PLLC revised 11/2022