

# REGIONAL PHYSICIANS

## Notice of Privacy Practices Receipt Acknowledgement

I have been presented with a copy of Regional Physicians Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Signature of Patient or Guardian \_\_\_\_\_  
Date of Receipt \_\_\_\_\_

(1) Please list the family members and/or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment & health care operations):

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

(2) Please list the family members and/or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

(3) Please list the telephone number(s) where you want to receive calls about your appointments, lab & x-ray results, or other health care information:

\_\_\_\_\_

(4) Can confidential messages (i.e. appointment information) be left on your answering machine?

\_\_\_\_\_ Yes \_\_\_\_\_ No

(5) Can we send you the following information electronically?

• Information about your medical conditions \_\_\_\_\_ Yes \_\_\_\_\_ No

• Information about health-related benefits or services that may be of interest to you  
\_\_\_\_\_ Yes \_\_\_\_\_ No

• Information about potential treatment options or alternatives  
\_\_\_\_\_ Yes \_\_\_\_\_ No

• Appointment reminders \_\_\_\_\_ Yes \_\_\_\_\_ No

\*\*\*Please note that if individuals other than you have access to the contents of this electronic mail address, those individuals could also have access to any information we send to you at that address. Regional Physicians will not be responsible if such individuals access information that is sent to the electronic mail address you provide.\*\*\*

**Please note that while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.**

Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt of Notice, please document the date and time the Notice was presented to patient and sign below: Presented on (date) \_\_\_\_\_  
Name/Title \_\_\_\_\_

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