FLORIDA HAND THERAPY AND REHABILITATION

ACKNOWLEDGEMENT OF HIPPA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Practice's Notice of HIPPA Privacy:

I have received a copy of the Notice of HIPPA Privacy for Florida Hand Therapy and Rehabilitation.

Name of Patient	Signature of Patient	Date

II. Designation of Certain Relatives, Close Friends and Other Caregivers:

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner:

Home Telephone Number: _____

❍ OK to leave message with detailed information
❍ Leave message with call back numbers only

Work Telephone Number: _____

❍ OK to leave message with detailed information
❍ Leave message with call back numbers only

B. I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____

C. The following person(s) <u>are not authorized</u> to receive my patient health information:

Print Name: _____

III. The Privacy Notice generally requires healthcare providers to take reasonable steps to limit use or disclose of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures make pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided above will constitute an adequate record. Uses and disclosures for Treatment/Payment, and Healthcare Operations may be permitted without prior consent.

Name of Patient	Signature of Patient/Guardian	Date