Debra S. Guthrie, M.D.
*****PLEASE PRINT CLEARLY*****

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician 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.

Print Name:_____ Last four digits of his/her SSN (required):_____
Print Name:_____ Last four digits of his/her SSN (required):_____
Print Name:_____ Last four digits of his/her SSN (required):_____

III. Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: **Written Communication Address:**
_____ **_____**

_____OK to leave message with detailed information _____OK to mail to address listed above

_____Leave message with call back numbers _____only E-mail me at:

Work Telephone Number: Fax Communication:
_____OK to leave message with detailed information _____OK to Fax at the number listed above

_____Leave message with call back numbers _____only E-mail me at:

Other:

_____ _____
Name of Patient (Print) Signature Date

Witness: _____ Date: _____