Senior Care
MEDICAL ASSOCIATES, INC.

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA)

Patient Acknowledgement of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read(or had the opportunity to read, if I so choose) and understand the notice.

X _____
Signature of Patient *or legal/personal representative*

_____ _____
Patient Name(PRINT) Date

_____ _____
Name of Authorized Representative(if applicable) Relationship to Patient

Authorization to Disclose Private Medical Information

Please list any person(s) you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Restrictions on Communication Methods

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/ voicemail. Please indicate below any ways in which you do **NOT** want to receive communications:

[ ] No restrictions

[ ] No calls to phone number(s):_ _____

[ ] No messages or voicemails left on phone number(s): _____

[ ] No mail to the following address(es): _____

[ ] Other (please specify): _____

X _____ _____
Signature of Patient or legal/personal representative Date

_____ _____
Name of patient or legal/personal representative Relationship to Patient