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HIPAA AWARENESS & ACKNOWLEDGEMENT

Patient Name: _____ DOB: _____

Our notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you for treatment, payment and health care operations (TPO).

The notice also describes in detail your rights to 1) authorize us to disclose your PHI to others, 2) access, inspect or receive a copy of your medical record, 3) have your medical information amended, 4) an accounting of disclosures we have made, 5) request restrictions on uses and disclosures of your PHI 6) right to request confidential communications and/or an alternative method of contact and 7) your right to notification if a breach of your medical information occurs.

The notice includes other important information, including instructions on how you may file a complaint about our privacy practices. We will not take any action against you or change our treatment of you in any way if you file a complaint.

Our notice of privacy practices is available on our web site and in our waiting room. You were offered a personal copy of our Notice upon check in today. We reserve the right to change the terms of our notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain. If we make changes to the Notice we will post the new Notice on our web page, provide copies of the new notice in the waiting room and make the notice available via email by contacting our Privacy Officer at privacyofficer@drtangoren.com.

I acknowledge that the practice uses e-mail and text messaging as well as traditional voice messages and automated calls for appointment reminders. I understand that if I provide a cell phone number and/or an email address I may receive appointment reminders in this manner. I understand that I have the right to opt out of these appointment reminder communications.

I acknowledge that the practice may leave a message on my answering machine (land line phones) or voice mail (cellular phones) regarding my care and treatment. Limited information will be left on messages and typically a call back will be requested. I understand I have a right to request confidential communications by alternate means by completing a Request for Alternate Means of Communications.

I am a patient (or a patient's parent or legal guardian) of I.A. Tangoren, M.D., P.L.L.C. and I hereby acknowledge receipt of the HIPAA Acknowledgement and notification of my right to review and have a personal copy of the practice's Notice of Privacy Practices.

_____ _____
Patient Signature or Signature of Patient's Authorized Representative Date

If signed by Patient's Authorized Representative, please print name and describe the representative's authority to act for the patient:

_____
Print Name of Patient or Patient's Authorized Representative

_____
Reason for Authority to Sign on Patient's Behalf

▼▼▼ FOR OFFICE USE ONLY ▼▼▼
Received by:
Date Received:
Patient Declined to sign☐
Staff Signature:

Effective 4/1/16