Austin
HAND TO SHOULDER
CENTER

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND RECORD OF DISCLOSURE

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I understand that as part of my health care, Austin Hand To Shoulder Center originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans my future care or treatment.

I understand that as part of Austin Hand To Shoulder Center treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I certify that I understand the privacy risks of the mail, phone calls, texts messages and email. I hereby authorize a representative or my physician to mail, call, text or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Austin Hand To Shoulder Center in writing.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____ Patient DOB: _____

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

I certify that I have received and read a copy of the Patient Information Privacy Policy.

Signature of Patient/Legal Guardian _____ Date _____

(To be completed if patient refuses to sign acknowledgement)

Date_____ Name of person providing notice _____