PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF THE PRIVACY PRACTICES

Please read and initial each statement to acknowledge that you understand and agree.

_____I acknowledge that I have the right to receive the practice's Notice of Privacy Practices, which describes the ways in which Robert D. Plambeck MD, PC may use and disclose my information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the provider and/or the provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practice.

_____I agree the provider or an agent of the provider may contact me for the purpose of scheduling necessary follow-up visits recommended by the treating physician.

_____If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email address or phone number I have provided. These instructions may include, but are not limited to post-procedure instructions, follow-up instructions, education information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided by your wireless plan.

It is okay to leave voicemail to: ____ Return clinic's call ____ A detailed message ____ Appointment reminders

_____I hereby permit this practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for the purpose of treatment and payment, or healthcare operations.

Authorization to Disclose Information

I give my permission to Robert D. Plambeck MD, PC for my protected health information to be disclosed including medical and financial information to the following individuals in accordance with their HIPAA policy:

Name(s)/Relationship: **Phone Number:**

_____ _____

_____ _____

Health Information to be disclosed (check all that apply):

____ My *complete* health record (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing for all conditions)

____ My complete health record, as above, *except* for the following information:

☐ Mental Health Records ☐ HIV & AIDS related testing

☐ Substance Abuse ☐ Other (please specify)

I understand and agree to these statements explained in this document by Robert D. Plambeck MD, PC

Today's Date: _____

(Print) Patient's Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Relationship to Patient:** _____