ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and read the Notice of Privacy Practices from Town & Country Neurology. I have also been given the opportunity to ask questions about this Notice. My signature below confirms that this has been provided to me.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

_____
Witness

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

☐ Home/Cell Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication _____
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

__ Other / Cell O.K. to leave detailed message

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment records; P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

PATIENT RECORD OF DISCLOSURES (continued)

On April 14, 2003, the Federal Government instituted the Health Information Portability and Accountability Act (HIPAA) setting specific limitations on patient confidentiality.

Town & Country Neurology adheres to the strictest guidelines concerning our patients' confidential medical and billing information. Due to the new HIPAA law we are unable to release any information concerning our patients without their specific written consent. You must give us written permission to discuss your health information/and or billing information.

In the space provided below please list the names of any family members or individuals you give us permission to speak with. You may choose to leave this blank if you wish your information not be released to anyone other than yourself. **(Please Print)**

Persons to Whom Information May Be Disclosed

_____

_____

_____

_____

Expiration Date of Authorization
This authorization is effective for 10 years as of the date of signing this document unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Town & Country Neurology. You should contact the Office Manager to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

_____
Name of Patient (Print or Type)

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship