Patient Acknowledgement Form for

Patient Name:

(Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The Practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information. Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the CobbWest Internal Medicine Associates, LLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: yes_____ no_____ Cell phone: yes____ no_____

Voice Mail/Answering machine: yes_____ no_____ Work phone: yes_____ no_____

Pager: yes____ no_____

May we fax medical records for referrals? yes_____ no_____

Please list names of people with whom we can discuss your medical care:

Spouse Name_____

Parent Name_____

Other Name (s) & Relationship _____
_____

Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier:_____(last four digits of your social security number or mother's maiden last name)

I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.
Signature of Patient or Personal Representative:
Date:

If Personal Representative, give relationship to patient:

Special Note on Authorizations Related to Marketing

HIPAA established special requirements for marketing activities. The patient's authorization must be obtained for all marketing activities except:
1. Face-to-face communication by the physician or other employee of the Practice; or
2. Promotional gifts of nominal value provided to the patient by the Practice.
In addition, the authorization must indicate whether the Practice receives direct or indirect remuneration from a third party in connection with the marketing activities.
Thus, to the extent the authorization concerns marketing activities, the following should be added to the form:

Marketing

This authorization authorizes marketing activities for which the Practice
¨ will ¨ will not receive direct or indirect compensation.
"Marketing" is defined by HIPAA to include all communications that encourage the purchase or use of a product or service except communications for:
1. Treatment;
2. Case management or care coordination of the individual, or to direct or to recommend alternative treatments, therapies, health care providers or settings of care; or
3. Certain other health plan communications concerning benefits.