# OLYMPUS FAMILY MEDICINE

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by the staff of *Olympus Family Medicine* in providing and arranging your medical care.

*Olympus Family Medicine* is furnishing you with the attached notice, which provides information about how we may use and/or disclose protected health information about you for treatment, payment, heath care operations and as otherwise allowed by the law.

## HIPAA PRIVACY ACT INFORMATION RELEASE FORM

May *Olympus Family Medicine* release medical information to anyone other than yourself?

___ **YES,** please release information to the following: ___ **NO,** only release information to me.

**Name**: _____ **Relationship**: _____

**Contact Phone #**: _____ **Email**: _____

**Name**: _____ **Relationship**: _____

**Contact Phone #**: _____ **Email**: _____

**Check which of the following methods we may leave detailed information pertaining to your health:**

____ Phone # _____

____ Voice Mail # _____

____ Email (Non-Encrypted) _____

**By signing this form, you acknowledge that you have received a copy of *Olympus Family Medicine's* Notice of Health Information Practices and have provided instructions regarding release of your individual healthcare information.**

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____

Print Name of Patient