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 law.

HIPAA PRIVACY ACT INFORMATION RELEASE FORM

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

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

Name: _____

Relationship: _____

Contact #: _____

Email: _____

Name: _____

Relationship: _____

Contact #: _____

Email: _____

Check which of the following we may leave detailed information:

____ Cell phone # _____

____ Voice Mail/ home answering machine # _____

____ 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

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