Drs. Phipps, Levin, Hebeka & Associates, LTD.
Bowling Green, Ohio 43402

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Drs. Phipps, Levin, Hebeka & Associates, LTD.. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Drs. Phipps, Levin, Hebeka & Associates, LTD. reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature (if 18 years old or older): _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Drs. Phipps, Levin, Hebeka, & Associates, Ltd.

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 protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Oral Communications:

Home Telephone #_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back #

Work Telephone #_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back #

Cellular Phone #_____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back #

Written communication:

- ☐ O.K. to Mail detailed information to my home address.
- ☐ O.K. to Mail detailed information to my work/office address.
- ☐ OK to Email detailed information to this email address_____
- ☐ O.K. to Fax detailed information to this number _____
- ☐ O.K. to Text Message detailed information to this number:_____
- ☐ Other _____
- ☐ **If checked, the following additional instructions apply:**

_____

_____

_____

Patient signature _____Date_____

Patient signature _____Date_____