sunRise MEDICAL GROUP
••• stay well, shine on •••

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Amy J Burke MD PC's Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its terms.

_____ _____

Name of Patient **Date of Birth**

_____ _____

Signature of Patient/Parent/Guardian **Today's Date**

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Amy J Burke MD PC will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____ **Phone Number:**_____

Print Name:_____ **Phone Number:**_____

Print Name:_____ **Phone Number:**_____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Primary Telephone Number: _____

Written Communication Address:_____

- **OK to leave message with detailed information on primary phone number voicemail: Yes or No (Circle One)**
- OK to mail to address listed above: Yes or No (Circle One)
- Leave message with call back numbers only E-mail me at:_____

Work Telephone Number:_____

- OK to leave message with detailed information
- OK to Fax at the number listed above
- Leave message with call back numbers only E-mail me at:_____

Other:

_____ _____ _____

Name of Patient (Print) Signature Date

Witness: _____ Date: _____