Notice of Privacy Practices Acknowledgement & Communication Preferences

Patient Name: **Date of Birth:**

Legal Guardian Name:

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Updated Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. I assume responsibility to inform the Practice of changes in my phone number(s) or my preferences or to revoke this authorization at any time.

Please indicate your communication preferences below:

Please circle preference

Cell: ____ 1st 2nd 3rd

Home: ____ 1st 2nd 3rd

Other: ____ 1st 2nd 3rd

Permission to leave a message on Answering Machine or Voice Mail: (please circle) YES NO

Email address: ____

Patient Portal enrollment status: (please circle) Enrolled Not Enrolled Declined

Do you want a reminder for future appointments? (please circle) YES NO

If yes, please choose: (please circle) Text Message or Phone Call

Emergency Contact:

Name: **Phone Number:**

We will not release any medical information to anyone other than yourself unless you wish for another person to have access to your medical information. Please indicate those individuals and their relationship to you (i.e. spouse, partner, etc.).

____ DO NOT release medical information to anyone other than myself

____ I give permission to release medical information pertaining to me to the individual(s) listed below:

Name: ______________________________ Relationship: __________________ Phone Number: ______________________

Name: ______________________________ Relationship: __________________ Phone Number: ______________________

Name: ______________________________ Relationship: __________________Phone Number: ______________________

Name: ______________________________ Relationship: __________________Phone Number: ______________________

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

You agree, in order for us to service your account or to collect monies you may owe, Medical Associates of the Lehigh Valley (LVPG MATLV), and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/ artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this disclosure and agree that Medical Associates of the Lehigh Valley (LVPG MATLV), its employees and/or agents may contact me/us as described above.

Printed Name of Patient or Patient's Legal Representative	Signature of Patient or Patient's Legal Representative	Date

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FOR OFFICE USE ONLY

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

______ **Patient or guardian refused to sign**
______ **Emergency situation**
______ **Other**