Medical Associates
OF THE LEHIGH VALLEY

Notice of Privacy Practices Acknowledgment & Communication Preferences

_____ _____
Patient Name or Legal Guardian (print) Date of Birth

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 and number preference (1 under Yes, 2 under Yes, etc.):

Primary Phone Number		Circle: Cell Home Other
Secondary Phone Number		Circle: Cell Home Other
Permission to leave a message on Answering Machine or Voice Mail	YES	NO
If you have not signed up for our patient portal, please enter your email address here or leave blank if you do not want to: _____		
Do you want a telephone reminder call for future appointments	YES	NO

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	AREA CODE & 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.

_____

Print Name of Patient or Patient's Legal Representative

_____ _____

Signature of Patient or Patient's Legal Representative Date