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