PRIMARY HEALTH SOLUTIONS (PHS)

Acknowledgement Of Receipt Of Privacy Practices

Today's Date: Month / Day / Year

PATIENT INFORMATION:					
Last Name	First Name	MI	Nickname	Social Security #	Birth Date Month / Day / Year

We are required to give each patient a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice and a copy of our patient brochure. You may refuse to sign if you wish.

Please answer the following questions so that we can contact you in the most efficient way possible.

May we send/receive clinical information from health care providers participating in your care? ☐ Yes ☐ No

If you have an answering machine at home, may we leave a message? ☐ Yes ☐ No

May we leave a message at your work for you to call our office? ☐ Yes ☐ No

Is there a person at your house that we may leave a message with? ☐ Yes ☐ No

If yes, please provide household members name: _____

List below any person/persons authorized by you to discuss/receive/access your medical information.

	Last Name	First Name	Relationship to Patient
1.			
2.			
3.			

By signing below, I authorize PHS to use/disclose my health information in a manner consistent with that stated in the Notice of Privacy Practices that I have received.

Guardian's Name (Print) _____ Relationship to Patient _____

Patient and/or Guardian's Signature _____ Date _____

☐ **Check here if you refuse to sign the acknowledgement of Receipt of Privacy Practices.**

Our Privacy Officer can be reached as follows:

Name of Privacy Officer: Peggy Vazquez

Practice Address: 300 N. High Street, 4th Floor
Hamilton, OH 45011
Phone: (513) 454-1111

PHS Staff Signature _____ **Date** _____