John A. Infantolino M.D. P.C.

5 Princeton Avenue, Brick Town, NJ 08724
(732) 840-0010

Acknowledgement of HIPPA Privacy Notice And Designation of Disclosure

I. Acknowledgement of Practice's Notice of HIPPA Privacy:

I have received a copy of the Notice of HIPPA Privacy for Physician Practice.

Name of Patient _____ Date of Birth _____ Signature of Patient/Parent/Guardian _____

II. Designation of Certain Relatives, Close Friends and other Caregivers:

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care of payment relating to my healthcare. In that case, thephysician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. *I wish to be contacted in the following manner (check all that apply):*

Home Telephone Number: _____

___ OK to leave message w/detailed information

___ OK to leave message with call back numbers only

Work Telephone Number: _____

___ OK to leave message w/ detailed information

___ OK to leave call back numbers only

Written Communication:

___ OK to mail to my home address

___ OK to mail to my work address

Fax Communication:

___ OK to fax to this number _____

___ OK to fax test results to other Dr.'s

___ other: _____

B. I designate the following persons listed below as persons involved w/ my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____ Tel # _____ last 4 digits of his/her SS # (required)_____

Print Name: _____ Tel # _____ last 4 digits of his/her SS # (required)_____

Print Name: _____ Tel # _____ last 4 digits of his/her SS # (required)_____

C. The following person(s) are not authorized to receive my patient health information:

Print name: _____ Print name: _____

_____ _____

Signature of Patient/Parent/Guardian ***Date***

III. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to the minimum necessary to accomplish the inteded purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

Date of request	Disclosed to whom; Address/fax#	Description of Disclosure	Purpose of Disclosure	Dates of Service of Disclosure	Person Completing Request	Date Completed