# Uses and Disclosures of PHI and Methods of Communication

## 1. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the _____ ("Practice") HIPAA Notice of Privacy Practices. By signing below, I consent to the uses and disclosures described under the heading: "**Uses and Disclosure of PHI that Do Not Require an Authorization**." Other uses and disclosures will require a separately signed authorization unless otherwise permitted by law. If I have a question or complaint, I understand that I may contact the Practice by phone at 1-877-373-1630 or by email at complianceGIA@gialliance.com.

## 2. DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

If you would like the Practice to share protected health information about your care with your friends or family members, please list the individual(s) who may receive your information below.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

## 3. TEXTS and EMAILS

Please check all that apply to you:

☐ I consent to receive text messages and/or calls from Practice (or its vendors), including calls and messages using automated dialing technology, at the cell phone number on file with Practice.

☐ I consent to receive emails from Practice (or its vendors) at the email address on file with Practice.

Calls, text and/or emails from Practice may include information relating to my healthcare services, financial obligations, appointment reminders, referrals, prescription information, or promotional or other marketing offers and services from Practice. I understand that these messages are unencrypted and there is risk that information included in the messages may be intercepted by unintended third parties and/or stored by our service providers and system operators. My consent is not a condition to receive services and message and data rates may apply. To stop receiving text messages, I may opt-out by texting STOP. To stop receiving email messages, I may opt-out by unsubscribing.

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By signing below, I agree to each of the above items (Section 1, Section 2 and each marked sentence of Section 3).

_____

Signature Date

_____

Printed Name of Patient

**If signed by patient's representative,** description of authority (such as parent/guardian):

_____

**FOR OFFICE USE ONLY**
**IF THE PATIENT DOES NOT ACKNOWLEDGE THE NOTICE**

The Practice has made a good-faith effort to obtain an acknowledgment of _____ (patient's name) receipt of our Notice of Privacy Practices. The Practice has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling
- ☐ Other _____

In an effort to obtain the patient's acknowledgment, the Practice has attempted to provide the patient with the Notice in the following manner (check all that apply):

☐ Personally ☐ Mail ☐ E-mail ☐ Other_____

_____ _____

Signature Date

_____

Printed Name of Practice Representative