



Notice of Privacy Practices Acknowledgement and Consent

NAME	DATE	DATE OF BIRTH
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT	<p>I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:</p> <ul style="list-style-type: none"> • Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. • Obtain payment from third-party payers. • Conduct normal healthcare operations such as quality assessments and physician certifications. <p>I have had the opportunity to understand your <i>Notice of Privacy Practices</i> containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its <i>Notice of Privacy Practices</i> from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the <i>Notice of Privacy Practices</i>.</p> <p>I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.</p>
SIGNATURE	RELATIONSHIP TO PATIENT

OFFICE USE ONLY	I attempted to obtain the patient's signature in acknowledgement on this <i>Notice of Privacy Practices Acknowledgement</i> , but was unable to do so as documented below:	
DATE	INITIALS	REASON

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION	<p><i>Patients 18 and over must complete the following:</i></p> <p>I hereby authorized Tidewater Physicians Multispecialty Group, PC, (TPMG) to use or disclose the following:</p> <p style="text-align: center;"> <input type="checkbox"/> All Protected Healthcare <input type="checkbox"/> Other _____ </p> <p>My protected health information may be disclosed to:</p> <p>(List all names) _____</p> <p>This protected health information is being used or disclosed to provide healthcare.</p> <p>This authorization shall be in force and effective until: (<i>check one of the following</i>)</p> <p style="text-align: center;"> <input type="checkbox"/> No expiration <input type="checkbox"/> Other _____ </p> <p>I understand that, as set forth in TPMG's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:</p> <p><i>Sibby Wilson, Tidewater Physicians Multispecialty Group, PC, 860 Omni Boulevard, Suite 401, Newport News, VA 23606</i></p> <p>I understand that I have the right to:</p> <ul style="list-style-type: none"> • Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or Virginia Law). • Refuse to sign this authorization.
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	DATE