



Notice of Privacy Practices Acknowledgement and Consent

PATIENT'S NAME	DATE	PATIENT'S 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	<p>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:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">DATE</th> <th style="width: 20%;">INITIALS</th> <th style="width: 60%;">REASON</th> </tr> </thead> <tbody> <tr> <td style="height: 40px;"> </td> <td> </td> <td> </td> </tr> </tbody> </table>	DATE	INITIALS	REASON			
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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><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:</p> <p><input type="checkbox"/> Enter date of expiration: _____</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: <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