Family Health and Sports Medicine
65 Sockanosset Cross Road #301
Cranston, RI 02920

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION

DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its terms.

Name of Patient_____

Date of Birth_____

Signature of Patient/Parent/Guardian _____

Date _____

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal

Representative:

I agree that the practice may disclose certain areas of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician 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.

Print Name:_____ Relationship_____
Phone Number: _____

Print Name:_____ Relationship_____
Phone Number: _____

_____
Name of Patient (Print)/Signature/ Date

Witness: _____ Date: _____