PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Porter Trust Employee Health Clinic
2801Bertholet Blvd., Suite 201
Valparaiso, IN 46383
Phone: 844-458-2800
Fax: 219-246-4146

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 pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare 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 healthcare or payment relating to my health care.

Print Name:______________________________________

Print Name:______________________________________

Print Name:______________________________________

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

______________________________ ______________________________________

Name of Patient (Printed) Signature of Patient Date