

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home telephone _____
- OK to leave message with detailed information _____
- Leave message with call-back number only _____

- Written Communication _____
- OK to mail to my home address _____
- OK to fax to number indicated _____

- Work Telephone _____
- OK to leave message with detailed information _____
- Leave message with call-back number only _____

I allow you to give my clinical information to, or answer questions from (check all that apply and list names):

- Spouse _____
- Parent _____
- Child _____
- Other (specify) _____
- None _____

I, _____, have reviewed a copy of Drs. Strull & Strull's notice of
(print patient name) Privacy Practices, and I have also been offered a copy.

Signature of patient, parent or guardian _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (specify): _____