



PACIFICA
MEDICINE & WELLNESS

Acknowledgement of Privacy Practices (HIPAA)

Acknowledgement

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

- § Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly
- § Obtain payment from third-party payers for my healthcare services
- § Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of Pacifica Medicine & Wellness' Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Pacifica Medicine & Wellness has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

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 health care operations. I further understand that Pacifica Medicine & Wellness is not required to accept my requested restrictions, but if they are accepted then I understand that Pacifica will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgement in order to receive treatment at Pacifica.

Authorization to Communicate Protected Health Information - Check all that apply:

- Pacifica may leave a detailed message on voicemail at my home #: (____) _____
- Pacifica may leave a detailed message on voicemail at my cell #: (____) _____
- Pacifica may speak with another person (spouse, family member) about my medical condition **including / excluding** information related to mental/behavioral health, substance abuse, sexually transmitted disease, HIV status and reproductive medicine: Name/Relation: _____ Phone #: (____) _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify Pacifica should I change one or more of the telephone numbers listed above.

PATIENT SIGNATURE: _____ **TODAY'S DATE:** / /

PATIENT NAME: _____ **DATE of BIRTH:** / /

PATIENT'S REPRESENTATIVE: _____ **TODAY'S DATE:** / /

RELATION TO PATIENT: _____

For administrative use only: We are unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons: Patient declined to sign Emergency situation Communication barriers Other: _____

