



Pueblo Community Health Center

HIPAA Acknowledgement & Confidential Communication Request

Date: _____

Patient Name: _____

Patient DOB: _____

ALL NEW PATIENTS MUST COMPLETE THIS FORM.

ACKNOWLEDGEMENT

I _____ (Patient Name) acknowledge receipt and reviewed the Pueblo Community Health Center Notice of Privacy Practices (please sign below).

I would like to receive a copy of any amended Notice of Privacy Practices by email: Yes No

If yes, please provide email address: _____

COMMUNICATION

I also would like Pueblo Community Health Center to follow these instructions when contacting me regarding my health care (please mark all that apply):

At day phone number listed (preferred contact number):

Leave messages on my answering machine/voice mail Allow Not allow
Leave messages with any other person Allow Not allow

At alternate phone number: (____) _____ - _____

Leave messages and tell them who is calling if asked Allow Not allow
Leave messages on alternate phone voice mail or answering machine Allow Not allow

Signature of Patient/Guardian: _____ Date _____

Parent/Guardian Name (Please Print): _____

If not signed by patient (or plan member), please complete section below and indicate your relationship:

- Parent/Guardian of minor patient.
Mother's Name: _____ Father's Name: _____
- Beneficiary or personal representative of deceased patient (Copy of court order needed)
- Guardian or Conservator of an incompetent person (Copy of court order needed)
- Other (specify) _____

Privacy Practice Acknowledgement must be signed before initial visit to Pueblo Community Health Center. You may end or change "Communication" section in this form at any time by filling out a new form. All previous "HIPAA Acknowledgement & Confidential Communication Request" forms will be void.

Staff Initials: _____ Dept: _____
Date sent to Med Rec: _____ Med Rec Clerk Initials: _____ Scanned Date: _____



Pueblo Community Health Center

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Patient DOB: _____

PATIENT WILL COMPLETE UPON REQUEST

AUTHORIZATION

I, _____, give my permission to Pueblo Community Health Center and/or any staff member of Pueblo Community Health Center, to discuss my health care with the individuals noted below who may, from time-to-time, help me receive and pay for health care. This may include, but is not limited to, attending my appointments, helping me follow treatment recommendations, picking up medicines, helping me understand my test results, helping me understand and make payments for health care

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Please note: This form does not replace the Release of Information form that must be completed to release PHI to another entity (person/business).

RESTRICTIONS

The following people shall not be allowed access to my Personal Health Information:

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient/Guardian: _____ Date _____

Parent/Guardian Name (Please Print): _____

If not signed by patient (or plan member), please complete section below and indicate your relationship:

____ Parent/Guardian of minor patient.

Mother's Name: _____ Father's Name: _____

____ Beneficiary or personal representative of deceased patient (Copy of court order needed)

____ Guardian or Conservator of an incompetent person (Copy of court order needed)

____ Other (specify) _____

You may end or change the directions in this form at any time by filling out a new form. All previous "HIPAA Acknowledgement & Confidential Communication Request" forms will be void.

Staff Initials: _____ Dept: _____

Date sent to Med Rec: _____ Med Rec Clerk Initials: _____ Scanned Date: _____