Blue Sky Neurology

Message Authorization, Authorized Disclosures and Acknowledgment of Notice of Privacy Practices

HIPAA Message Authorization

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have the right to request that communications concerning your protected health information (PHI) be made by alternative means or at an alternative location(s). The Practice will do its best to accommodate all reasonable requests.

I, _____ (print name) hereby request the following changes be made in the way the office communicates with me regarding my personal health, treatment or payment for treatment:

Description of special communication methods to be used (Please specify alternate telephone numbers, alternate mailing addresses, etc.): _____

_____

_____

Disclosures to Friends and/or Family Members

I hereby authorize and consent to the release and disclosure of my Protected Health Information for the purpose of communicating results, findings, care decisions and information to the friends, family members and others listed below:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Acknowledgement of Notice of Privacy Practices

_____ _____

Name of Patient (please print) Date of Birth

I hereby acknowledge that I received the Notice of Privacy Practices of Blue Sky Neurology.

_____ _____

Patient Signature (or patient representative) Date

Documentation of Good Faith Efforts

To obtain patient's acknowledgement that they received the Notice of Privacy Practices of Blue Sky Neurology.

____ Patient refused to sign
____ Patient was unable to sign because: _____
____ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
____ Other reason (describe below):

_____ _____

Employee Witness **Date**