Shalom Medical, PC

1102 Henderson Drive, Jacksonville, NC 28540 P 910.333.9712 F 910.333.9715

Notice of Privacy Practices Acknowledgement

A federal regulation known as the “HIPPA Privacy Rule” requires that we provide you with a detailed notice in writing of our privacy practices. It also requires us to address any special needs you may have to assure your patient information is kept confidential.

May we leave a message on your answering machine if you are not available? Yes No

May we leave results of any diagnostic test on your answering machine if you are not available? Yes No

May we call you at work with test results or other health related issues? Yes No
If so, what is your work number? ________________________

Other than yourself, do you authorize our office to discuss your health information with any other person(s): (For example, your spouse, child or parents.)

If so, please list names below for our record. If you do not list someone on this release, we **cannot** give out information even in an emergency.

Name: _______________________________________
Relationship:___________________________________

Name: _______________________________________
Relationship: __________________________________

Name: _______________________________________
Relationship: __________________________________

Name: _______________________________________
Relationship: __________________________________

Consent for Purposes of Treatment, Payment and Health Services

I consent to the use or disclosure of my protected health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Shalom Medical, P.C.

Shalom Medical, P.C. will accept written revocations of the authorization via: Certified U.S. Mail.

All revocations must be sent to Shalom Medical, P.C. to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer. This authorization shall expire on termination of the relationship. After termination has been received, Shalom Medical, P.C. can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I fully understand and accept the terms of this authorization.

________________________________ __________________________

Patient Name (Print) Date

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Signature