Baptist Health Family Clinic – Otter Creek

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

The signature below acknowledges a copy of this notice was received (not necessarily read).

______________	________________________________
Date	Patient/Legal Representative Signature
	________________________________
	State Capacity, if Legal Representative

This section for internal use only

Lack of patient acknowledgement:

Date	Reason	Staff signature

Designation of
Personal Representative

As part of this clinic's compliance with privacy regulations as set forth by the Health Insurance and Portability Act of 1996, we request that you designate individuals for your physician to discuss your care with.

Upon signing, I understand that my physician may discuss information pertaining to my diagnosis and continuing care with the person(s) listed below.

My signature also allows these designated individuals to discuss my medical bills with the billing office.

Designated individual ____

Designated individual ____

Patient signature ____

Date ______________

This form is not to be substituted for a HIPAA authorization form for medical records. Copies of medical records must be processed through the clinic office staff.