Pembroke Family Medicine
860 Main Road 319 West Main 3384 Church Street
Corfu, NY 14036 Batavia, NY 14020 Alexander, NY 14005

Phone (585)599-6446
Fax (585)599-3166

Authorization of Notice of Privacy Practices (HIPAA)

Patient Name: ______________________________

Date of Birth: __ __ / __ __ / __ __ __ __

I have received Pembroke Family Medicine's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my Protected Health Information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted to or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of the other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual right with respect to protected health information and a brief description of how I may exercise these rights with relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to the requested restriction.
    - The right to receive confidential communications of my protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

We offer different ways to contact you. In accordance with our Notice of Privacy Practices, **we will contact you by home/cell/work telephone (including voicemail), mail, email/portal, and/or with who answers the number you have supplied us with regarding appointment reminders, and by home/cell telephone (including voicemail) and/or mail, email/portal regarding medical information.**

Patients have the right to request changes to our Privacy Practices. If you wish to do so, requests for changes must be submitted in writing.

****Please Continue to the Other Side****

Form Not Valid Unless Signed

I grant permission to the following individuals to speak to or to receive medical information in regard to myself:

Name: ____________________

Relationship to Patient: ____________________ Emergency Contact: (yes/no)__________

Address: ____________________

____

Home Phone: ____________________

Cell Phone: ____________________

Name: ____________________

Relationship to Patient: ____________________ Emergency Contact: (yes/no)__________

Address: ____________________

____

Home Phone: ____________________

Cell Phone: ____________________

Name: ____________________

Relationship to Patient: ____________________ Emergency Contact: (yes/no)__________

Address: ____________________

____

Home Phone: ____________________

Cell Phone: ____________________

Name: ____________________

Relationship to Patient: ____________________ Emergency Contact: (yes/no)__________

Address: ____________________

____

Home Phone: ____________________

Cell Phone: ____________________

Name of Patient: ____________________
Or Personal Representative

Signature: ____________________ Date: ____________________
or Personal Representative

Form Not Valid Unless Signed