Primary Care Partners
Affiliated with
Atlantic Health System

HIPAA Acknowledgement & Release Form

Notice of Privacy Practices

Print Name of Patient _____ Date of Birth _____

We, at Primary Care Partners, are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Release of Information

Please let us know how your personal health information may be released

☐ I am the only one who should receive information regarding my personal health information. Best way to contact me:

☐ Home phone _____ Permission to leave a message **Y** **N**

☐ Cell Phone _____ Permission to leave a message **Y** **N**

☐ I, _____, authorize the release of my medical information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐Spouse _____

☐Child(ren) _____

☐Other _____

Signed: _____ Date _____

Witness:_____ Date _____