Health Insurance Portability and Accountability Act (HIPAA) Form

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Monocacy Health Partners, have been offered a copy of the Notice of Privacy Practice which describes my privacy rights in accordance to federal and state requirements.

______________________________________ ____________________

Signature of Patient or Authorized Representative   Date

Communication Consent

"I understand that I may be contacted by Frederick Regional Health System/Monocacy Health Partners and or its affiliates on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages, and /or an automated dialing device (auto dialer) or by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services. You may also contact me by e-mail using any e-mail address I have provided to you.

☐ Yes, you may call or text my cell phone at: ____________________________. This communication is to confirm office appointments or leave a message regarding my care.

☐ ***No***, please ***do not*** contact me by the following means: ____

I authorize my provider and the appropriate staff to share medical/billing information about my care/account to the following individuals as indicated below:

Name(s)	Relationship(s)	Phone #(s)

<u>It is the patient's responsibility to notify Monocacy Health Partners of any changes to this form.</u>

______________________________________ ______________________________

Print Patient's Name   Home/Cell Phone Number (Please circle)

____

Patient's Date of Birth

______________________________________ ______________________________

Patient or Legally Responsible Person's Signature   Date   Witness   Date

Office Use Only

Entered by: __________ Date:

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