SURGICAL GROUP OF JOHNSON CITY, MPC

HIPAA PATIENT PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have received notification that access to a copy of **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, Notice regarding Privacy of Personal Health Information is available upon request. In order to ensure that your health information remains confidential and to protect the staff of **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, we require authorization to speak to or leave messages with anyone other than the patient.

Patient/Guardian Signature:_____ Date:_____

I give my permission for the Practice of **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, including the staff, to speak with the contacts listed below (Please include the area code with all phone numbers):

Name:_____Phone #:_____Relationship to Patient:_____

Name:_____Phone #:_____Relationship to Patient:_____

Name:_____Phone #:_____Relationship to Patient:_____

May we leave test results on your answering machine/voicemail? Yes_____ No_____

May we contact you at work? Yes_____ No_____ Phone #:_____

I authorize any staff member of **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, to send correspondence to me by mail regarding appointments, any test results, treatments, account balances, and office updates.

Yes_____ No_____ Mailing Address:_____

If **S**urgical **G**roup of **J**ohnson **C**ity, **MPC**, needs to call in or e-Prescribe medication for me, I would like to use the following pharmacy:

Pharmacy Name:_____ Pharmacy Street/City:_____
Pharmacy Phone #:_____

I authorize Surgical Group of Johnson City to verify my electronic medicine history **Y** **N**

Please note that if the patient is a minor and parents are separated/divorced, both parents have a legal right to the minor child's healthcare information unless otherwise prohibited by a court of law. If this is the case, documentation will need to be provided. Additionally, if the patient has a Power of Attorney, that person must sign all paperwork at each visit as necessary and a copy of the documentation must be on record with us prior to the patient being seen by our physicians.

This authorization will remain in effect until revoked by me in writing.

Patient/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____