His Branches Health Services

Grace Family Medicine
340 Arnett Blvd., Rochester, NY 14619
Phone: (585) 235-2250 ● Fax: (585) 235-0011
Web: www.gfm3.org

Joy Family Medicine
918 N Goodman St., Rochester, NY 14609
Phone: (585) 697-0004 ● Fax: (585) 697-0046
Web: www.joymed.org

ACKNOWLEDGMENT FORM
Notice of Privacy Practices

The copy of the Notice of Privacy Practices (NPP) provided, describes how medical Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. **Please read it carefully before signing this form.**

To Summarize:

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communication.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of the Notice of Privacy Practices.

We want to assure you that your medical PHI is secure with us. The NPP contains information about how we will insure that your information remains private.

If you have any questions about the NPP, you may contact the Practice Manager.

Acknowledgment of Notice of Privacy Practices

"I hereby acknowledge that I have reviewed a copy of this practice's NPP. I understand that if I have questions or complaints regarding my privacy rights that I my contact the Practice Manager. I further understand that the practice will offer me updates to the NPP should it be amended, modified, or changed in any way."

_____
Patient or Representative Name (please print)

_____ _____
Patient or Representative Name Signature Date

_____ Patient refused to sign _____ Patient was unable to sign because:

Office Copy

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MESSAGE AUTHORIZATION

Please check one of the following.

1. ___I authorize His Branches Health Services to leave messages on my answering machine or with any individuals at my home.

2. ___I do not authorize His Branches Health Services to leave messages on my answering machine or with any individuals at my home.

If #2 is checked, please complete the statement below <u>if desired:</u>

___ I authorize His Branches Health Services to leave messages on the answering machine or with any individuals at a number *other* than my home number.

This number is _____ specify: ___ cell ___work ___other (describe) _____

I understand this is a legally binding document. Any changes made after the date of signing need to be done so in writing. Correspondence should be addressed to:

Practice Manager
His Branches Health Services
342 Arnett Boulevard
Rochester, NY 14619

<table>
<tr><td colspan="3">Date _____</td></tr>
<tr><td>Print Patient Name:</td><td rowspan="3">OR</td><td>Print Name of Legal Representative:</td></tr>
<tr><td rowspan="2">Patient Signature</td><td>Relationship to the Patient:</td></tr>
<tr><td>Signature of Legal Representative</td></tr>
<tr><td colspan="3">Witness:</td></tr>
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PRIVACY RIGHTS

- I understand that I do not have to sign this form and that His Branches Health Services will not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits on whether or not I sign this authorization.
- I understand that I may change my mind and revoke this authorization at any time by notifying His Branches Health Services in writing; however, such revocation does not affect any action taken by His Branches Health Services before receiving my written revocation.
- I understand that the information released in accordance with this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

I understand this is a legally binding document. Any changes made after the date of signing need to be done so in writing. Correspondence should be addressed to:

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3rd PARTY DISCLOSURE

Important note to our valued patients: This form must be filled out completely in order to be valid.

I, _____, authorize His Branches Health Services to release the following (please check one):

A __ All medical information, including information related to confidential communicable disease, HIV or AIDS-related illness, alcohol or drug abuse, cancer and/or genetic conditions, and mental health diagnosis and treatment information.

B __ Only the following described medical information:

_____
_____
_____
_____

Specifically describe the information to be used or disclosed, including, but not limited to dates of service, type of service provided, level of detail to be released, origin of information, etc.

I authorize the release of this information to the following person(s):

_____ (Name)	_____ (Relationship)	_____ (Phone)
_____ (Name)	_____ (Relationship)	_____ (Phone)
_____ (Name)	_____ (Relationship)	_____ (Phone)

The purpose of this release is: _____

Examples: At my request; to resolve my appeal; to assist with my health insurance services

I understand that this authorization will expire on ____/____/_____(mm/dd/yyyy) **OR** on the **occurrence of the following event:**

_____

Examples: Until I revoke this authorization; resolution of a specific issue

_____ _____
Patient or Representative Name Signature Date