THE PEAK PHYSICAL MEDICINE

NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGEMENT

We are committed to safeguarding the privacy and confidentiality of your medical record including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following:

Patient Name (please print): ______________________________

Date of Birth: ______________________________

Home Phone: ____________________

May we leave a voice mail message for you here? Y N

Work Phone: ____________________

May we leave a voice mail message for you at work? Y N

May we speak to someone else regarding your medical care? Y N

Name of person:	Relationship:
______________________________	________________
______________________________	________________

PRESCRIPTION RELEASE/HIPAA NOTIFICATION

I, __________________________ acknowledge that I am the only person that is allowed to pick up my prescriptions at The Peak Physical Medicine.

I have been made aware of the privacy policies of The Peak Physical Medicine and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices.

Signed:____________________________________ Date:______________