_____
Patient Name

_____
Date of Birth

_____
The last 4 of Social

Acknowledgement of Receipt of Notice of Privacy Practices and Express Consent of Communication

HIPAA & Your Protected Health Information
The use and disclosure of Protected Health Information (PHI, aka Medical Records) is regulated by the Health Insurance Portability and Accountability Act of 1995 (HIPAA). Under HIPAA, we are required to give patients our Notice of Privacy Practices for PHI. HIPAA also requires that adult patients specify to whom (if anybody) we may release their PHI.

Patient Instructions for PHI Communications
I authorize **Stankus Family Care** to leave messages, including certain medical information. By selecting "YES" below, you hereby give express consent for **Stankus Family Care**, its employees, and agents to contact you at the phone numbers listed to communicate with you about your interaction with our practice; including lab, test results, and healthcare information. You may cancel this consent at any time by completing a new form.

YES NO **You may leave messages on my answering machine or voicemail in regards to my medical care.**

May send text messages on my cell phone # at: _____

May share information with the following individuals:

Name	Phone Number	Relationship

Please read and sign next page

Express Consent of Communication
In addition, to the above-listed Authorization or Denial of Authorization, as a patient or representative of a patient, you hereby authorize **Stankus Family Care**, our employees, and/or our agents to contact you and leave messages about your appointment reminders and billing/collections. This consent also authorizes such communications to be sent by the automated dialers and messaging equipment.

Acknowledgment
I acknowledge that I have read the above paragraphs, that **Stankus Family Care** has made available to me a written copy of its Notice of Privacy Practices for me to read on behalf of myself, my family, and/or my dependent, and that I give Express Consent to Communication.

Authorization of the Release of PHI
I attest that I am the patient, legal guardian, or Power of Attorney of the patient and authorize the release of PHI to the Individual(s) listed above for the next 18 months. I understand that I may rescind this authorization at any time by completing a new form.

_____ _____
Signature of Patient (or guardian) Date

To be completed by **Stankus Family Care, LLC**: We have made a good faith effort to provide thabove-nameded patient with a copy of our Notice of Privacy Practices, but were not successful for the following reasons:

☐ PATIENT REFUSED ☐ OTHER: _____

_____ _____
Employee Name Title

_____ _____
Employee Signature Date