PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Omnibus Rules of 2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Rao Plastic & Hand Surgery (RPS), which contains a more complete description of the uses and disclosures of my health information. I understand that RPS has the right to change its Notice of Privacy Practices from time to time and that I may contact RPS at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that RPS restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand RPS is not required to agree to my requested restrictions, but if RPS does agree then RPS is bound to abide by such restrictions.

Patient Name:____**Patient DOB**:____________________________

Signature:____**Date Signed**:_____________________________

REQUEST FOR CONFIDENTIAL COMMUNICATION

HIPAA privacy rules give certain individuals the right to request confidential medical information. In that regard, you may select the method in which this confidential medical information is communicated. Also, RPS may need to communicate with you regarding your confidential medical information. Please select your preferred method of contact. If you would like to change your contact information in the future, please provide your request in writing to the address contained within the Privacy Practice Notice.

I give permission to disclose my confidential medical information to the following individuals:

Printed Name:___________________________________ Relationship: ______________________________

Emergency contact is:_________________________________Phone #___________________________________

I prefer to be contacted in the following manner (check all that apply):

Home Phone: Δ Detailed Message OR Δ Callback Number Only

Work Phone: Δ Detailed Message OR Δ Callback Number Only

Written Communication: I give my consent to be contacted in the following ways:

Mail to Home Δ Email to:____Δ Fax to: _________________

Signature:____**Date Signed**: ____________________________

RPS OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: ____________________ Employee Name:____

Reason: ____________________