

Coastal Healthcare

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. Acknowledgement of Privacy Practice Notice:

I have been offered a copy of *Coastal Healthcare's* Notice of Privacy Practices.

Patient Name: _____ Date of Birth _____

2. I wish to be contacted in the following manner (check all that applies):

Home Telephone (OK to leave a detailed message) Number: _____

Check if it is **not** ok to leave a detailed message on your answering machine and a message with only the Doctor's name and number will be left.

Cell Telephone (OK to leave a detailed message) Number: _____

Check if it is **not** ok to leave a detailed message on your cell phone and a message with only the Doctor's name and number will be left.

Work Telephone (OK to leave a detailed message) Number: _____

Check if it is **not** ok to leave a detailed message at work and a message with only the Doctor's name and number will be left.

Written Communication: Unless otherwise instructed written communications will be mailed to the home address on file.

3. *Coastal Healthcare* operates as a multispecialty group with various offices that have access to your information and may exchange the details from our shared database.

4. Designation of Certain Relatives, Close Friends and Other Caregivers:

I agree that *Coastal Healthcare* may disclose certain of my health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, *Coastal Healthcare* will only disclose only information that is relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following person listed below as a person involved with my healthcare or payment relating to my healthcare for the purposes of *Coastal Healthcare* to make the type of disclosures listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

Print Name (other than patient) 1) _____ 2) _____

Relationship to Patient: 1) _____ 2) _____

Date of Birth: 1) _____ 2) _____

Telephone #: 1) _____ 2) _____

Signature of Patient/Parent/Guardian

Date