RECEIPT OF NOTICE OF PRIVACY PRACTICES – WRITTEN ACKNOWLEDGEMENT FORM

Jonathan Riegler, MD
1255 Las Tablas Rd., Ste. 201, Templeton, CA 93465
Phone: 805-434-2434 Fax: 805-434-5249

Patient Name:_____Date of Birth:____/___/____
Please print

I give my permission to discuss medical information with the following family members or designated persons. I understand that due to HIPAA guidelines, medical information will only be discussed with me and those listed below except as allowed by law. Medical information may include, but is not limited to appointments, prescriptions and test results.

1._____DOB____/____/____Relationship_____Tel#_____

2._____DOB____/____/____Relationship_____Tel#_____

3._____DOB____/____/____Relationship_____Tel#_____

I give my permission to release information to the following Physicians or Medical groups:

_____

_____

****I give my permission to leave detailed medical information on my answering machine. (circle one) Yes No**

This office has always kept your medical and financial records private. However, as mandated by federal law, we are required to advise you in writing of these regulations.
The full notice describes in detail how medical information about you may be used and disclosed and how you can get access to this information. You may read the full N.P.P. if you desire.

(A) Your medical record is the property of Jonathan Riegler M. D. However, information in the record belongs to you. The law permits us to disclose this information for the following purposes:

1. Medical treatment such as with other physicians or laboratories.
2. Payment from your insurance plan.
3. Heath care operators such as billing clearing houses who work with us.
4. Appointment reminders, by mail or messages left on an answering machine or with someone else at home, unless you object.
5. Notification and communication with family members or relief organizations in the event of emergency.
6. As required by law, such as domestic violence or abuse.
7. Public health, such as communicable diseases.
8. Judicial or Health Oversight activities or law enforcement.
9. To comply with workers compensation laws.
10. To transfer your information to new owners of this practice if necessary.

(B) Except as described above, this medical practice will not disclose your health information in any way that identifies you without your written permission.

(C) Your Health Information Rights:

1. Right to request certain privacy protections, in writing.
2. Right to request confidential communication.
3. Right to inspect and copy, for a fee, certain parts of your records.
4. Right to try to amend or supplement your record.
5. Right to accounting of certain disclosures of your health information.

(D) You have the right to file a complaint of how this practice handles your health information.

_____ **Date**_____

Patient Signature