BENACARE MEDICAL CENTER, INC.
PATIENT ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 have been informed by you of your **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **NOTICE OF PRIVACY PRACTICES** prior to signing this consent. I understand that this organization has the right to change its **NOTICE OF PRIVACY PRACTICES** from time to time and that I may cause this organization at any time at the address below to obtain a current copy of the **NOTICE OF PRIVACY PRACTICES**.

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

I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

Patient Name: _____

Signature: _____ Relationship:_____

Authorized Representative:_____ Date: _____/_____/_____

Designated Family Member Authorization Form *(optional)*
Protected Health Information will only be released from this office with a properly executed authorization from patient or his/her personal representative, except for treatment, payment, or health care operations (TPO), and as otherwise required by law.

However, in the event that a family member is required to discuss my medical condition, I assign the following person to be the primary source of communication regarding my medical condition. Additionally, I understand that this authorization will remain in effect until revoked in writing by me.

Authorized Person: _____ Relationship:_____ Birthdate:_____/_____/_____

Signature of Patient: _____ Date:_____/_____/_____

Answer Phone Authorization Form *(optional)*
I give the above entity my permission to leave non-emergency messages or normal tests results on my answer phone. I understand this authorization will remain in effect until revoked in writing by me.

Signature: _____ _____Date:_____/_____/_____
PATIENT OR LEGAL GUARDIAN RELATIONSHIP

Email & Mail Authorization Form *(optional)*
I give the above entity my permission to email & mail non-emergency messages and/or test results to my designated email address and home address. I understand that communication by email can be non-confidential, and this authorization will remain in effect until revoked in writing by me.

Email Address: _____

Signature: _____ _____Date:_____/_____/_____
PATIENT OR LEGAL GUARDIAN RELATIONSHIP