1801 16th Street, Suite A
Bakersfield, CA 93301
Phone: 661-326-8989 Fax: 661-326-8991

Patient Name: _____ Date of Birth: _____
(Please Print)

HIPAA PRIVACY DISCLOSURES AND RESTRICTIONS

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

Home Phone: _____

□ OK to leave message at home
□ Leave message with call-back number only
□ Do not leave message
□ Do not call at home

Alternate Phone: _____

□ OK to leave message at alternate number
□ Leave message with call-back number only
□ Do not leave message
□ Do not call

Written Communication:

□ OK to mail to my home address
□ Do not mail to my home address

Email/Other: _____
_____
_____

Signature: _____ Date: _____

PRIVACY PRACTICES DOCUMENTATION

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state laws, and outlining my rights regarding my health information.

Signature: _____ Date: _____

TO BE COMPLETED BY FRONT OFFICE

Written acknowledgment could not be documented due to:
□ Patient refused to sign
□ Personal representative not available to sign
□ Language, communication, or effects of disability impeded acknowledgment
□ Other, please specify _____