

**Acknowledgment of Receipt of Notice of Privacy Practices**

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

I have been presented with a copy of Alabama Thoracic Surgery, LLC’s Notice of Privacy Practices, detailing how the above-named patient’s information may be used and disclosed as permitted under federal and state law.

In the event of a medical emergency or if I am otherwise unavailable, I hereby allow Alabama Thoracic Surgery, LLC to discuss billing, appointments, treatment, diagnosis, test results, and other protected health information regarding the above-named patient with the following persons who are involved with the patient’s health care and/or payment related to the patient’s health care:

<u>Name</u>	<u>Relationship</u>	<u>Contact #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contact Methods:

May we leave information on your answering machine at home?	Yes	No
May we leave information on your voicemail at work?	Yes	No
May we leave information on your cell phone?	Yes	No

I understand the contents of the Notice of Privacy Practices, and I request the following restriction(s) concerning the use and/or disclosure of my personal medical information (*include type of information covered and the parties who should not receive the information*):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that Alabama Thoracic Surgery, LLC will carefully consider my request, but is not obligated to accept the request unless the request is to restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations and the information pertains solely to a health care item or service for which Alabama Thoracic Surgery, LLC has been paid in full other than by the health plan.

The request stated herein  **does or**  **does not** restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations with the information pertaining solely to a health care item or service for which Alabama Thoracic Surgery, LLC has been paid in full other than by the health plan

**My signature below is acknowledgment that I have received a copy of Alabama Thoracic Surgery, LLC’s Notice of Privacy Practices and that I agree to the conditions stated in it and contained in this form.**

\_\_\_\_\_  
Printed Name of Patient \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Printed Name of Parent/Patient’s Representative (If Applicable)

\_\_\_\_\_  
Signature of Parent/Patient’s Representative (If Applicable)