Tarrant Medical, P.C.

Sidney R. Shah, M.D.
2038 Springdale Ln, Birmingham, AL 35217
(205) 841-7665

Acknowledgment of Receipt of Notice of Privacy Practices with Restrictions

Patient Name: _____ Patient Date of Birth: _____

I have been presented with a copy of Tarrant Medical, P.C.'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 Tarrant Medical, P.C. 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:

Name	**Relationship**	**Contact #**

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 Tarrant Medical, P.C. 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 Tarrant Medical, P.C. 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 Tarrant Medical, P.C. has been paid in full other than by the health plan

My signature below is acknowledgment that I have received a copy of Tarrant Medical P.C.'s Notice of Privacy Practices and that I agree to the conditions stated in the Notice of Privacy Practices 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)