Essential Family Health & Wellness
Acknowledgement of Privacy Practices and Instructions for Release of Personal Health Information / HIPAA

PATIENT NAME: ____

DATE OF BIRTH: ____

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES: __________

I give permission to Essential Family Health & Wellness to communicate messages regarding APPOINTMENTS as follows:

______ You may leave a message on my voice mail /answering machine
______ You may leave a message with ____
______ You may communicate with me through the Patient Portal
______ Please communicate appointment messages as follows: _________________________

I give permission to Essential Family Health & Wellness to communicate messages regarding REFERRALS TO ANOTHER PHYSICIAN as follows:

______ You may leave a message on my voice mail /answering machine
______ You may leave a message with ____
______ You may communicate with me through the Patient Portal
______ Please communicate appointment messages as follows: _________________________

I give permission to Essential Family Health & Wellness to communicate messages regarding LAB RESULTS, X-RAYS AND OTHER TESTS as follows:

______ You may leave a message on my voice mail /answering machine
______ You may leave a message with ____
______ You may communicate with me through the Patient Portal
______ Please communicate Test Result messages as follows: _________________________

Names of individuals who we have permission to release your health information to:

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____

Signature of Patient, Parent or Legal Guardian: _____________________________________

Date: ______________________________