ORCHARD PARK FAMILY PRACTICE

SERVICE - COMPASSION - ACCOUNTABILITY

HIPAA (Health Insurance Portability Accountability Act)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that Orchard Park Family Practice, consisting of Richard Ruh, MD, Thomas DeGrave, DO, Julie Thomas, DO, Andrei Sfintescu, DO, Leah Speciale, FNP, Amy Pohlman, RPA-C, Breanna Voigt, RPA-C, Susan Patronik, Mpas, PA-C, Sarah Piasecki, PA share my health information for treatment, billing and healthcare operation. I have been given a copy of the Notice of Privacy Practices that describes how my health information is used and shared. My signature constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices and have read the assignment of benefits information.

Printed Name of Patient _____ **Date of Birth** _____ **Today's Date** _____

Please **PRINT** any names of family members or other persons who we may inform of your general medical condition, your diagnosis and your appointments.

Name of Contact Person _____Relationship_____

Address_____

Home # _____ Cell # _____

Name of Contact Person _____Relationship_____

Address _____

Home# _____ Cell# _____

Please **PRINT** any names of family member or other persons who we may inform of your general medical condition ONLY IN AN EMERGENCY SITUATION if different from names listed above.

Name of EMERGENCY CONTACT _____**Relationship**_____

Home# _____ Cell# _____

Name of EMERGENCY CONTACT _____Relationship_____

Home # _____ Cell # _____

Please **CIRCLE** where we may leave MEDICAL information:

Home Phone Cell Phone Mobile Text Work Phone With Another Person

US Mail Via Personal/Business Email _____ Via Patient Portal

ELECTRONICALLY SIGNED
Patient/Guardian Signature **Today's Date** _____
Updated: 02/2018