Patient Name	Patient Date of Birth

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Primary Care Associates, PC *Notice of Privacy Policy* and have been provided an opportunity to review it. _____ (Initial)

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home.

I understand Primary Care Associates will take all reasonable steps to ensuring my medical records are kept confidential. I give Primary Care Associates permission to contact me at the address(es) and phone number(s) provided to them. _____ (Initial)

INFECTION CONTROL

If any employee of Primary Care Associates of other health care worker is exposed to my blood or other body fluids, I hereby authorize Primary Care Associates to test my blood for Hepatitis B, Hepatitis C, and HIV (the virus that causes AIDS). I understand the tests will be done at the expense of Primary Care Associates. _____ (Initial)

RELEASE OF CONFIDENTIAL INFORMATION FOR BILLING PURPOSES

Disclosure of substances abuse, psychiatric treatment, and HIV information are protected by federal and state law. Federal and state law prohibit making any disclosure of confidential information without the consent of the person to whom it pertains, or as otherwise permitted or required by federal or state law. The undersigned hereby authorizes Primary Care Associates and affiliates and any involved physician(s) and/or employees to release to the patient's insurance company or other third party payer, for the purpose of securing payment of insurance benefits, information contained in the patient's medical record regarding the patient's treatment for alcohol or drug abuse, the patient's treatment for mental illness, and the fact that an HIV test was performed on the patient and the patient's HIV test results.

Signature of Patient or Authorized Representative	Print Name	Date

Witness: _____