

**PATIENT PRIVACY POLICY
ACKNOWLEDGEMENT FORM**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to **Protected Health Information (PHI)**. In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their 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 individual's home. If you have any objections to this form, please ask to speak with our HIPPA compliance officer in person or by phone at (423) 622-2494.

Patient Name _____

- | | |
|---|---|
| <input type="checkbox"/> Home Telephone
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only. | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home
<input type="checkbox"/> O.K. to mail to my work
<input type="checkbox"/> O.K. to fax to this number |
| <input type="checkbox"/> Work Telephone
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only. | <input type="checkbox"/> Other _____
_____ |

Authorization to release Protected Health Information to individuals/family members

_____ I authorize Chattanooga Surgical Oncology & Associates to verbally, or with written consent, release any or all of my PHI to the following individuals:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

_____ I do not authorize Chattanooga Surgical Oncology & Associates to release any or all of my PHI to any individuals/family members except as set forth above.

Patient Signature _____ Date _____

Witness _____