Individual Notice of Privacy Practices Acknowledgement

I acknowledge that I received a copy of CHI/Memorial Health Partners Foundation Notice of Privacy Practices (v03/2016) for (print patient's name) ______________________.

______________________ ______________________ OR
Signature of Patient Patient's DOB

____
Signature of Patient Representative or Parent/Legal Guardian if Under 18

______________________ ______________________
Signature of Witness Date

Designation of Persons Involved in a Patient's Care or Payment for Care

Privacy laws allow health care providers to disclose to a spouse, family member, relative, or a friend of a patient protected health information (PHI) directly related to such person's involvement with the patient's treatment and care or payment related to the care. **No special authorization or formal permission from the patient is required.**

However, to make these relationships clear for CHI Memorial Health Partners Foundation and its providers, CHI Memorial Health Partners Foundation allows patients to provide the names of those individuals that could be involved with the patient's care or payment related to their care to facilitate accurate sharing of necessary information. Be advised that under privacy laws, health care providers may also use their professional judgment in sharing necessary information to family, friends, or other involved parties that are not listed here.

Designation of Involved Individuals
Individuals that are or would be involved in my care or payment of my care are listed below. My signature below represents that I do not object to CHI Memorial Health Partners Foundation sharing my PHI with these individuals:

Patient information

Patient Name (Please Print): ______________________ Patient Date of Birth: __________

Last four digits of SSN: __________

Signature of Patient or Parent/Legal Guardian/Personal Representative: ______________________

Relationship to Patient: ______________________ Today's Date: ______________________

Persons involved in my care or payment for care

Name (Please Print): ______________________ Relationship to Patient: __________

Address: ______________________ Phone: ( ) __________

Name (Please Print): ______________________ Relationship to Patient: __________

Address: ______________________ Phone: ( ) __________

Please note that privacy laws also allow health care providers to share PHI **without special authorization or formal permission** in the case of emergencies or to avert imminent threat of harm or risk to safety to any appropriate individuals.

This form does not restrict uses and disclosures as allowed under applicable privacy laws. For other allowable uses and disclosures of PHI please see the CHI Memorial Health Partners Foundation Notice of Privacy Practices.