Manassas Internal Medicine

Privacy Disclosure Form

Client Name:

_____

Manassas Internal Medicine (MIM) respects your right to privacy. You, as a client, have the right to make certain choices about the uses and disclosures of your health information. Any information you authorize for use and disclosure may be re-disclosed and is no longer protected. You may amend your elections for restrictions by contacting the Privacy Officer.

- I authorize and consent to the release of my health information to the following individuals:

_____ _____ _____

Name of Person or Persons

- I would like to receive all written communications at the following location rather than my home address (if none specified, written communications will be forwarded to your home address):

_____

P.O. Box or Street Address, City, State, Zip

I would like to receive appointment reminders and patient care follow-up communications only by the following means (*check all that apply*):

- ☐ Mail
- ☐ Home Phone ( ) _____
- ☐ Work Phone ( ) _____
- ☐ Cell Phone ( ) _____

NOTE: Manassas Internal Medicine reserves the right to implement stricter privacy standards under certain circumstances which it deems necessary for the protection of the patient.

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I acknowledge that I have been given the Manassas Internal Medicine NOTICE OF PRIVACY PRACTICES and have had the opportunity to ask questions about the information provided in the notice. I understand that I have the right to request other reasonable requests regarding confidential communications by contacting the Privacy Officer as specified in the NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship

Effective 4/14/2003