Health Insurance Portability and Accountability Act (HIPAA)

This form applies to all specialties within Frederick Health Medical Group.

Frederick Health Medical Group

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Frederick Health Medical Group, have been offered a copy of the Notice of Privacy Practice, which describes my privacy rights in accordance to federal and state requirements.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE _____ DATE _____

Communication Consent

I understand that I may be contacted by Frederick Health/Frederick Health Medical Group and or its affiliates on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages, and /or an automated dialing device (auto dialer) or by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services. You may also contact me by e-mail using any e-mail address I have provided to you.

☐ Yes, you may call or text my cell phone at: _____
This communication is to confirm office appointments or leave a message regarding my care.

☐ **No**, please **do not** contact me by the following means: _____

I authorize my provider and the appropriate staff to share clinical/medical/billing information about my care/account to the following individuals as indicated below as my Next of Kin and Person to Notify.

NAME of **Next of Kin**	RELATIONSHIP	PHONE	LANGUAGE

NAME of **Person to Notify**	RELATIONSHIP	PHONE	LANGUAGE

☐ Same as Next of Kin

It is the patient's responsibility to notify Frederick Health Medical Group of any changes to this form.

PRINT PATIENT'S NAME _____ PATIENT'S DATE OF BIRTH _____

HOME/CELL PHONE NUMBER (PLEASE CIRCLE ONE) _____

PATIENT OR LEGALLY RESPONSIBLE PERSON'S SIGNATURE _____ DATE _____

WITNESS _____ DATE _____