Steffen S Cameron MD, LTD
HIPAA
Patient Acknowledgment Form

Patient's Name:____

Patient's D.O.B.:__________________________

Persons with access to Medical records: (Only persons listed below will be able to obtain medical information about you. If someone calls who is NOT listed, we CANNOT and WILL NOT

Emergency Contact
Name:______________________________Phone#______________________
Relationship to patient:____

Name:____Phone#__________________________
Relationship to patient:____

Name:____Phone#__________________________
Relationship to patient:____

How would you like us to contact you
Home:____________________
Work:_____________________
Cell:______________________
Ok to leave a message Y N

The patient understands that:

- ***Protected health information may be disclosed or used for treatment, payment or health care operations.***
- ***The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.***
- ***The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.***
- ***The patient may revoke this Consent in writing at any time and all future disclosures will then cease.***
- ***The practice may condition treatment upon the execution of this Consent.***

By signing below, I certify that I have read, understand and agree to the content. I also understand that this form will remain the same and in effect until I request the change in writing(including new form).

Patient Signature:____
Relationship to patient (if minor):____________________________________
Date:____________________

For Office Use Only:

Signature of PRACTICE REPRESENTATIVE:______________________________