



HIPAA – Patient Acknowledgement Form

I, _____, hereby acknowledge receipt of Northwest Pulmonary Associates, SC's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me.

I authorize Northwest Pulmonary Associates, SC to discuss my medical treatment with:

Only Myself: _____ at Phone Numbers: _____

And the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Messages may be left on my answering machine or voicemail including test results:

YES: _____ NO: _____

Messages may be left with one of the people listed above:

YES: _____ NO: _____

Can we send you text messages?

YES _____ NO: _____ Phone Number: _____

Patient Name:: _____ Signature: _____

Date: _____ Witness: _____