SYMMETRY FAMILY HEALTH
Sandra Brown, APRN, FNP-BC

Patient Privacy Notification Form

Due to the Health Insurance Portability and Accountability of 1996 (HIPA.1). Symmetry Family Health or any of its associates are unable to release any medical or billing information to anyone other than the patient without written consent by the patient.

Patient Name: _____   Date of Birth: _____

Approved Communication Methods:

Is it ok to leave detailed messages on your voicemail?   Yes/No   Phone Number: _____

Is it ok to send text message reminders?   Yes/No   Phone Number: _____

Is it ok to send detailed information to your email?   Yes/No   Email Address: _____

Personal Representatives:

You have the right to authorize Symmetry Family Health to disclose or provide your protected health information, such as appointment and billing information and test results, to individuals of your choice who may act as a personal representative. As a designated personal representative, they may exercise your right to inspect, copy, and correct your personal health information. I understand that protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer by the responsibility of Symmetry Family Health. By listing the individuals below, you are designating them as your Personal Representative and therefore access to **ALL** your medical and billing information.

O None- I opt out of designating a personal representative at this time.

Name of Personal Representative	Relationship	Date of Birth	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This authorization will remain in effect until terminated in writing by you, your personal representative or legal entity authorized to do so by court of law. You are not required to complete or sign this form. By declining to complete this form, Symmetry Family Health will not withhold services. Symmetry Family Health will be unable to discuss your medical or billing information with anyone other than you, to include spouses, parents, and children.

_____   _____

Patient/Guardian Signature   Date

_____   _____

Patient/Guardian Printed Name   Relationship to Patient