



SUMMA HEALTH CARE
Receipt of Notice of Privacy Practices

Summa Health Care respects your privacy and only uses or discloses your medical information when necessary or appropriate. Our attached Notice of Privacy Practices describes potential uses and disclosures of your health information by our practice and outlines your medical privacy rights.

Please sign below and return this form to the receptionist so that we know you have read and understand our HIPAA Notice of Privacy Practices.

Date: \_\_\_\_\_

Name of Patient (Please Print): \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Name of Personal Representative (Please Print): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_

Due to HIPAA regulations we are not able to release any information about your account, treatment given, appointments, or billing information without your expressed written permission. Is there anyone that you would allow us to speak with on your behalf such as a relative/family member, friend, personal nurse? If so, please list them below. Thank you.

Table with 3 columns: Name, Relationship, Contact Number. Rows 1-4 for listing contacts.

I authorize this office to contact me for appointments, treatment, and billing information via: (please check one)

- Cell Phone, Home Phone, Work Phone, Email, ANY OF THE ABOVE

May we leave a voicemail about your appointments, treatment, and billing information?

- Yes, No

What is the best number to leave a message at? \_\_\_\_\_

Signature: \_\_\_\_\_