Acknowledgment of Receipt of Privacy Practice/ Opportunity to Object or Agree

This document is intended to comply with 45 C.F.R. § 164.520 (c) and 45 C.F.R. § 164.510.
If you have any questions about this document, contact the Privacy Contact at 415-785-7995.

In general, the HIPAA privacy rule is intended to give further protection for patients' privacy of medical records and information. As of April 14, 2003, federal law restricts the dissemination of your personal information to any entity other than those that you have specifically indicated by an information release form. Please sign below to acknowledge that you received a copy of our HIPAA Notice of Privacy Practices.

Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore we must have clear information regarding how we may communicate with you regarding your personal medical information. Please fill in the means by which we may communicate with you below.

FILL IN THE APPROPRIATE INFORMATION AND CIRCLE YES OR NO

I wish to communicate in the following manner(s):

Phone Number:
Please leave messages with detailed information. **Y / N**
Please leave messages with callback number only. **Y / N**
Mailing Address:
Please send written communications and lab results to this address. **Y / N**
Please use this address for medication and product shipment. **Y / N**

<u>Please Note** Email is not a HIPAA compliant form of communication. If you need to speak to Dr. Motykie regarding medical questions or concerns, please contact our office at (310) 246-2355:</u> Initial _____**

I hereby acknowledge that I received the HIPAA Notice of Privacy Practices for Gary Motykie, M.D. I agree with and to the privacy practices detailed therein; and I authorize the use of the above means for communication of my personal health information.

Patient's Signature **Date**

Please Print Name