

# Coastal Healthcare

## ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. **Acknowledgement of Privacy Practice Notice:**

I have been offered a copy of *Coastal Healthcare's* Notice of Privacy Practices.

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. **I wish to be contacted in the following manner (check all that applies):**

**Home Telephone (OK to leave a detailed message) Number:** \_\_\_\_\_

Check if it is **not** ok to leave a detailed message on your answering machine and a message with only the Doctor's name and number will be left.

**Cell Telephone (OK to leave a detailed message) Number:** \_\_\_\_\_

Check if it is **not** ok to leave a detailed message on your cell phone and a message with only the Doctor's name and number will be left.

**Work Telephone (OK to leave a detailed message) Number:** \_\_\_\_\_

Check if it is **not** ok to leave a detailed message at work and a message with only the Doctor's name and number will be left.

**Written Communication:** Unless otherwise instructed written communications will be mailed to the home address on file.

3. *Coastal Healthcare* operates as a multispecialty group with various offices that have access to your information and may exchange the details from our shared database.

4. **Designation of Certain Relatives, Close Friends and Other Caregivers:**

I agree that *Coastal Healthcare* may disclose certain of my health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, *Coastal Healthcare* will only disclose only information that is relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following person listed below as a person involved with my healthcare or payment relating to my healthcare for the purposes of *Coastal Healthcare* to make the type of disclosures listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

**Print Name (other than patient) 1)** \_\_\_\_\_ **2)** \_\_\_\_\_

**Relationship to Patient: 1)** \_\_\_\_\_ **2)** \_\_\_\_\_

**Date of Birth: 1)** \_\_\_\_\_ **2)** \_\_\_\_\_

**Telephone #: 1)** \_\_\_\_\_ **2)** \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date