Heritage Valley Health System
Corporate Compliance Program

HIPAA Privacy Practice Acknowledgment Statement

I acknowledge I have received a copy of Heritage Valley Health System Notice of Privacy Practice for Protected Health Information.

_____ _____

Patient Name *(Please Print)* Date of Birth

_____ _____

Patient Signature Date

List any family or friends (if any) that we may talk to regarding your healthcare.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

List any family or friends (if any) that you authorize to pick up healthcare information such as medical records, prescriptions, medical supplies, etc. on your behalf.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Print the telephone number(s) you would like to receive calls about your appointments or test results.

_____ May we leave a detailed message at this number? ☐ ☐

(Telephone Number) Yes No

_____ May we leave a detailed message at this number? ☐ ☐

(Telephone Number) Yes No

I understand that this authorization will stay in effect until revoked by me in writing.