S A R A

SOUTHERN ARIZONA RADIOLOGY ASSOCIATES

# HIPAA CONTACT CONSENT

**Acknowledgement of Receipt of Notice**

The Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of our healthcare services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide treatment and will use and disclose your protected health information for treatment, payment and healthcare operations when necessary.

Initial: _____

C**ontact Consent**

Please select the phone numbers where our office staff may leave telephone messages.

**Home** _____ □ **Yes** □ **No**

**Cell** _____ □ **Yes** □ **No**

**Work** _____ □ **Yes** □ **No**

**Email** _____ □ **Yes** □ **No**

Please list the names of any individuals that our office staff has permission to speak with or contact in case we are unable to reach you directly. This includes any members of your family or friends that may inquire about appointments or care. If they contact our office and they are not listed, we will **NOT** release **ANY** information.

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

I have reviewed the information above and confirm that it is accurate.

_____ **Date:** _____/_____/_____

***Patient signature (or legal guardian)***