JOSEPH R. RACCUGLIA, MD
family medicine

HIPAA – Acknowledgement and Authorization

1. Patient Acknowledgement:

Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), our office is required by law to maintain the privacy of protected health information (PHI), and provide individuals with Notice of our legal duties and privacy practices with respect to PHI. Though our HIPAA – Notice of Privacy Practices may be revised from time to time, the current information is posted on our website, www.RaccugliaMD.com and is always available at our office for your review.

Your signature below is your acknowledgement that you have been provided the opportunity to review our HIPAA – Notice of Privacy Practices document.

Name:_____ Date of Birth:_____

Signature:_____ Date:_____

2. Authorization for Disclosure of Protected Health Information (PHI) and Billing information.

I authorize that the following individuals are permitted to receive protected health information (PHI) with regard to any medical history and treatment(s) that I have received. They may also access billing information and act on my behalf with respect to matters of billing:

Name:_____ Relationship:_____ DOB:_____ Phone #:_____

Name:_____ Relationship:_____ DOB:_____ Phone #:_____

Restrictions:_____

In accordance with Health Insurance Portability & Accountability Act of 1996 (HIPAA), I understand that I may revoke this authorization at any time by way of my issuance of a replacement practice "HIPAA – Acknowledgement and Authorization" form. My revocation will take effect at the time that the replacement form is received by the practice. This authorization replaces any prior authorizations that I have made regarding to the use, release and disclosure of my medical and billing information, collectively PHI.

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