NEUROLOGY GROUP OF BERGEN COUNTY, P.A.

**HIPAA**

**Receipt of Notice of Privacy Practices**

**Written Acknowledgement Form**

Patient's Name:_____ has received a copy of the Neurology Group of Bergen County's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian Relationship to Patient

_____ _____
Print Name of Parent or Legal Guardian Date

## Patient Authorization For Use And Disclosure of Protected Health Information

I wish to be contacted at the following number :_____
(You may be left a detailed message concerning your appointment or other details of your medical care at this number.)

**I give permission to have medical/appointment/billing information left on my:**

**Home Answering Machine** ☐ **Yes** **No** ☐ **Cell Phone** ☐ **Yes** **No** ☐

**Work Phone** ☐ **Yes** **No** ☐ **E-mailed to me** ☐ **Yes** **No** ☐

I give permission for the individual(s) listed below to speak with your office or to leave information regarding medical/appointment/billing :

| **Name(s) & Relationship(s)** | **Phone Number(s)** |
|---|---|
| | |
| | |
| | |

**HIPAA privacy rules give you the right to request a restriction of your protected health information. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule.**

**By signing this authorization, you are providing us with permission to contact you by E-mail. If you do not authorize us to communicate with you in this manner, please check "No."** ☐ **No**

_____
**Signature of Patient or Legal Guardian** **Relationship to Patient** **Date**

**This authorization will expire on**_____