PRIVACY PRACTICES INFORMATION

In general, The HIPPA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of his/her home address.
The privacy rule generally requires health care providers to take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.

Uses and disclosures may be permitted without prior consent in an emergency.

NOTE: *It is very important that you complete this section so that we may contact you. IE: changing your appointment, notification of test results, etc…*

I wish to be contacted in the following manner: (check all that apply):

- ☐ Home Telephone________________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave Message with call back number only
- ☐ Written Communication other than billing statements
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work/office address
- ☐ Work Telephone _________________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave Message with call back number only
- ☐ Fax Number________________________________
- ☐ Other:_____________________________________
- ☐ Cellular Number _________________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave Message with call back number only
- ☐ Email Address______________________________
  ____
  ____

I authorize ONE Health to contact me using the contact information including email, which I have provided. Your privacy is important to us. Your contact information will only be used by ONE Health Ohio during the course of normal business. It will never be sold.
I agree to ONE Health Ohio to communicate with the following individuals on my behalf, should I be unable to be contacted. *Should any of these individuals need to pick-up or drop-off personal information, up to and including prescriptions, they understand they must provide proper identification that coincides with their information below.*

Name/Relationship:_________________________________ Phone#:____________________________ DOB:__________________

Name/Relationship:_________________________________ Phone#:____________________________ DOB:__________________

Name/Relationship:_________________________________ Phone#:____________________________ DOB:__________________

Name/Relationship:_________________________________ Phone#:____________________________ DOB:__________________

Please sign and date the acknowledgement below. Thank you

I, ____, acknowledge and agree that I have received a copy of ONE Health Ohio's Notice of Privacy Practices.

Patients Signature: ____ Date: ________________________________

Guardian Signature: ____ Date: ________________________________

Relationship to patient: ____

For Center Use Only

ONE Health Ohio has made the following good faith effort to obtain the above referenced individuals written acknowledgement of receipt of Privacy Practices.

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other:____

Staff Signature: ____ Date: _________________________

Patient Record of Disclosures

NOTE: Health Care entities must keep record of PHI disclosures. The information listed below is a record of all disclosures made for this patient.

Date	Disclosed To	(1)	Purpose of Disclosure	Staff Initials	(2)	(3)

(1) Check this box if disclosure is authorized
(2) Type Key: T=Treatment Records; P=Payment Information; O=Health Care Operations
(3) Enter How Disclosure Made: F=Fax; P=Phone; E=Email; O = Other