UNC REGIONAL PHYSICIANS
UNC HEALTH CARE

HIPAA Authorization

Notice of Privacy Practices Receipt Acknowledgement

Patient name _____

Date of birth _____ Patient # _____

I have been presented with a copy of UNC Regional Physicians Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

Patient or Guardian Signature | Date of Receipt

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1. Please list the family members and/or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name | Phone Number

Name | Phone Number

Name | Phone Number

2. Please list the family members and/or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name | Phone Number

Name | Phone Number

Name | Phone Number

3. Please list the telephone number(s) where you want to receive calls about your appointments, lab and x-ray results or other health care information:

4. Can confidential messages (for example, appointment information) be left on your answering machine?

☐ Yes ☐ No

5. Can we send you the following information electronically?

Please note if other individuals have access to the contents of this electronic mail address, those individuals may have access to any information we send at that address. UNC Regional Physicians will not be responsible if such individuals access information sent to the electronic mail address you provide.

- Information about your medical conditions: ☐ Yes ☐ No
- Information about health-related benefits or services that may be of interest to you: ☐ Yes ☐ No
- Information about potential treatment options or alternatives: ☐ Yes ☐ No
- Appointment reminders: ☐ Yes ☐ No

Please note: while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

Internal Use Only

If patient or patient's representative refuses to sign Acknowledgement of Receipt of Notice, please document the date and time the Notice was presented to patient and sign below: Presented on _____

Date | Name/Title