HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND COMMUNICATION AUTHORIZATION

I, _____, acknowledge that I have been informed that MedFast Urgent Care Centers' ("MEDFAST") **Notice of Privacy Practices** is posted in the waiting area and that I may request a copy at any time.

The Notice explains how my Protected Health Information (PHI) may be used and disclosed for treatment, payment, and healthcare operations, and describes my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that MEDFAST may use and disclose my PHI as permitted or required by law, with or without my authorization, for these purposes.

My treatment is not conditioned on signing this acknowledgement.

Changes to Privacy Practices

MEDFAST reserves the right to change its privacy practices as described in the Notice of Privacy Practices. Any revised Notice will apply to PHI maintained by the practice, including information created or received prior to the change.

Communication Authorization

I understand that MEDFAST will take reasonable safeguards to protect my information, however, communications by telephone, voicemail, text message, fax, or email may carry a risk of unauthorized access. It is MEDFAST's policy not to release confidential or unauthorized information, except for appointment confirmations by home telephone answering machine, work telephone, voice mail, cell phone, or pager. When returning phone calls, if an answering machine responds and the name or telephone number does not identify the residence or recipient, no message will be left. Information will not be left with an unauthorized person who answers the phone.

By selecting the options below, I authorize MEDFAST to communicate with me regarding my care using the following methods:

Communication Method	Yes	No
Home Telephone / Answering Machine	☐	☐
Work Telephone	☐	☐
Voice Mail	☐	☐
Cell Phone / Voice Mail	☐	☐
Pager	☐	☐

MEDFAST may require reasonable identity verification before releasing information by phone or electronic means.

Fax Authorization

May we fax minimum necessary medical records for referrals or continuity of care?

☐ Yes ☐ No

Authorized Individuals

I authorize MedFast Urgent Care Centers to discuss information related to my care, appointment scheduling, and billing with the following individuals:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Disclosures to the individuals listed above are limited to information directly related to my care unless otherwise required by law.
This authorization may be changed or revoked in writing at any time and will not affect disclosures already made.

Patient Information (Print)

Patient First Name: _____
Patient Last Name: _____
Person Signing (check one):
☐ Patient ☐ Parent/Guardian ☐ Legal Representative
Signature (Patient): _____
Date: ____ / ____ / _____

If Not the Patient

Signee First Name: _____
Signee Last Name: _____
Signature: _____
Date: ____ / ____ / _____
Parent/Guardian / Legal Representative (Print): _____
Relationship to Patient: _____
Date: ____ / ____ / _____