DeWitz Family Medicine PLLC

Heartfelt care for the whole family

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HIPPA Acknowledgement and Consent Form

Patient Name_____Date_____

Please initial if you understand and agree to the following statements:

- **I have received a copy of the notice of privacy practices, and have been offered a copy to take with me._____**
- **If I have any questions or complaints, I will contact Dr. Dewitz_____**
- **My personal, protected medical information may be transmitted electronically as permitted by law and as needed for my care_____**
- **My personal, protected medical information may be shared with other healthcare professionals, and organizations as needed for the purposes of my treatment, or payment._____**
- **If I am covered by Medicare, I authorize the release of any of my personal, protected medical information to the Social Security Administration or its intermediaries or carriers for payment of a claim.**
- **I give permission to leave messages involving my personal, protected medical information on my voicemail or answering machines at the following numbers:**

  _____

  _____

  _____
- **Please do not leave messages at these numbers**

  _____

  _____

  _____
- **You may share my protected medical information with the following people**

Name	Relationship	Phone number

Patient or representative_____Date_____