# Thomas L. Anderson & Associates
# Notice of Privacy Practice Signature Form

### Acknowledgement of Receipt of State of Privacy Practices

I acknowledge that a copy of the Statement of Privacy Practices for Thomas L. Anderson & Associates was made available for me. I have review the Statement of Privacy Practices describing the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and responsibilities; and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Thomas L. Anderson & Associates reserves that right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

### Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

**Any member of my immediate family** ○ YES ○ NO

**Spouse only** ○ YES ○ NO

**Other (Please Specify Below):** ○ YES ○ NO

I authorize that I may be contacted via the way listed below in regards my treatment, payment for services, or in the performance of office health care operations.

**E-mail** ○ YES ○ NO

**Telephone Messages** ○ YES ○ NO

**Text Messages** ○ YES ○ NO

**Fax** ○ YES ○ NO

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_____ _____ _____

**Name of Patient or Personal Representative** **DOB** **Signature of Patient or Personal Representative**

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**Description of Personal Representative's Authority** **Date**

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### Office Use Only

**Date Provide:**_____

**Reason for denial:**_____

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