Receipt of HIPAA Notice and Designated Communications

I. Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have been provided a copy of the practice's Notice of Privacy Practices and have thereby been notified of how my protected health information (PHI) may be used and/or disclosed, and of my rights and the practice's legal obligations with respect to my PHI. I understand that I may contact the ATX Robotic Surgery's Department of Compliance & Privacy as designated on the notice if I have a question or complaint.

Print Name: ____________________________ Signature: _______________________ Date: ________________

Relationship to Patient (Please select one): Self ☐ Parent ☐ Legal Guardian☐

II. Designated Communications

Family Member/Patents*/Friends: ATX Robotic Surgery may share my information with the following designated individuals:

Printed Name: _______________________________________ Relationship: ____________________________________

Printed Name: _______________________________________ Relationship: ____________________________________

**Patients aged 18 years or older. Please note that we cannot discuss your healthcare, insurance or payment with your parents/others unless you fill out the appropriate information above.*

I may revoke my designations above in writing by completing a new Receipt of HIPAA Notice and Designation form except to the extent that the practice has already made disclosures in reliance upon my prior designation.

Print Name: ____________________________ Signature: _______________________ Date: ________________

Relationship to Patient (Please select one): Self ☐ Parent ☐ Legal Guardian☐

For special requests to identity specific person(s) not authorized to receive PHI, speak directly with the Practice Manager.