Annapolis Family Medicine

William Dabbs, M.D. | Kastle Donovan, C.R.N.P. | Amy Ricker, C.R.N.P. | Catherine Wilson C. R.N.P | Eileen Delaney, C.R.N.P.

Printed Patient Name: _____ **DOB:** _____

HIPAA Acknowledgment

I, _____, Patient Name (please print) hereby acknowledge receipt of the AFM HIPAA Policy given to me.

_____

Patient or Representative Signature

PATIENT HIPAA COMMUNICATION

It is the policy of Annapolis Family Medicine not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment. ***Updates to this form must be made in person.***

Name	Relationship	Phone

Name	Relationship	Phone

Name	Relationship	Phone

_____ _____

Patient or Representative Signature **Date**