ANNAPOLIS FAMILY MEDICINE

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HIPAA Acknowledgment

Patient Name: _____ DOB: _____

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 responsibly infer from the circumstance (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.

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

_____ _____

Patient/Representative Signature* Date

*Signing will hereby acknowledge receipt of the AFM HIPAA Policy.
**Any updates to this form must be made in person.