James A. Stoever, D.O. & Chelsea Stoever, PA-C
705 E. 70th Street Savannah, GA 31405
Phone 912/354-7622 Fax 912/354-7628
www.theendoclinic.com

HIPAA ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Note: This form must be signed at the beginning of each year

Name ____
Last *First* *Middle Initial*

Date of Birth _________/________/_____________ Social Security Number _________- _________-__________

I understand that the patient's health information is private and confidential. I understand that The Endocrine Clinic, P.C. will strive to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that The Endocrine Clinic, P.C. may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment and to take care of other healthcare operations. (In general, there will be no other uses and disclosures of this information unless I permit it. I understand that the law may require the release of this information without my permission. These situations are very unusual. An example would be if a patient threatened to harm another.)

The Endocrine Clinic, P.C. has a detailed document called the "Notice of Privacy Practices." If I ask, the practice will provide me with the most current version of that document.

Within this "Notice of Privacy Practices' is a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law and requesting communication can be by specified methods or alternative location.

This practice has established procedures which helps it meet the obligations to the patients. These procedures may include other signature requirements, written acknowledgements, and authorizations, reasonable timeframes for requesting information, charges for copies and non-routine information needs, etc. I will assist The Endocrine Clinic, P.C. by following these procedures if I choose to exercise any of my rights in the "Notice of Privacy Practices."

	Yes	**No**
May we leave messages on your answering machine/ voicemail?	☐	☐
May we leave messages at home with other residents?	☐	☐
May we contact you via email or cellular telephone?	☐	☐

My signature below indicates that I have been given an opportunity to review a current copy of The Endocrine Clinic, P.C. "Notice of Privacy Practices."

______________________________ ________________ ________________
Patient's Signature Date Signed Time Signed

______________________________ ______________________________
Signature of Witness Parent, Legal Guardian, or Personal Representative's Signature

I authorize the following person(s) to have access to my health information:

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________