PBMC HEALTH | Anchored by Peconic Bay Medical Center

PBMC Medical Group

Peconic Bay Primary Medical Care PC Prime Care Medical of Long Island PC Peter G Sultan, MD PC

ACKNOWLEDGEMENT OF "NOTICE OF PRIVACY PRACTICES"

Dear Patient,

According to HIPAA Federal Regulations, each patient must be assured that his / her medical records are held in the strictest confidence. In order for PBMC Medical Group to comply with those regulations, we ask that you take a moment to complete the following questionnaire.

****Please note: Your signature is required below.**

With what individuals MAY we disclose your PHI information? (I.e. test results, medical history, diagnosis' and conditions)

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

****OR****

_____ **By INITIALING here, I am requesting that my information NOT be discussed with ANY family member.**

Please provide your contact information and your preferred method of contact:

(Circle One Preferred Method of Contact)

Home Phone: Y N (____) _____

Cell Phone: Y N (____) _____

Work Phone: Y N (____) _____

Email Address: _____@_____

Note: PBMC Medical Group utilizes an outside vendor to automate Patient Appointment Reminder calls to either your home or cell phone number supplied above.

I understand that PBMC Medical Group will adhere to the regulations as outlined by HIPAA and will follow the guidelines I have outlined above.

I have received or reviewed the Notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosures of my protected health information that may be made by this Group, my individual rights, how I may exercise these rights and the Group's legal duties with respect to my health information.

I understand that PBMC Medical Group reserves the right to change the terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this Group. If changes occur, the Group will provide me a revised Notice of Privacy Practices upon request. I also understand that without a signed consent from the patient, medical information will not be released to any unauthorized individuals.

Patient Name: _____ Date of Birth: _____ /_____ /_____
Mon Day 4 Digit Year

Signature of Patient: _____ Date:_____

Signature of Parent / Guardian:_____ Date:_____
(If Applicable)