TUSTIN IRVINE INTERNAL MEDICINE GROUP, INC.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice. I hereby acknowledge that I have reviewed a copy of the Notice of Privacy Practices and that any amendments will be available at my next appointment.

Patient Name: ______________________________ Date: ______________________________

Signature: ______________________________ Telephone: ______________________________

Patient Representative: ______________________________ Relationship: ______________________________

AUTHORIZATION TO LEAVE MESSAGES

I authorize Tustin Internal Medicine Group, Inc. to leave messages regarding my protected health information (PHI) on my telephone answering machine or with a family member or other designated party.

Tustin Irvine Internal Medicine Group, Inc. may share information about my condition with:

____

Name Relationship Telephone Number

____

Name Relationship Telephone Number

Home phone: ______________________________ Cell phone: ______________________________

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices" for Tustin Irvine Internal Medicine Group, Inc., but was unable to do so as documented below:

Date:	Initials:	Reason: