

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

GEISINGER

Name: _____

Med Record #: _____

Date of Birth: _____

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and coordinate treatment among multiple healthcare providers who may be involved in my care directly and indirectly
- Obtain payment for services from insurers and third-party payors
- Conduct routine healthcare operations
- For other permissible reasons such as Worker's Compensation and public health reporting

I further understand and consent for Geisinger¹ and its HIPAA business associates to contact me regarding payment and billing issues, and that if I provide a mobile number or email address, I may be contacted via email or text for these purposes (normal text and messaging rates may apply). I understand that I have the right to opt out of such communications at any time.

I acknowledge that I have received, read and understand Geisinger's Notice of Privacy Practices which contains a more complete description of how my PHI can be shared, how Geisinger may communicate with me using the information I provide, and I have had an opportunity to ask questions.

Patient signature: _____ Date/Time: _____

Signature of Personal/Legal Representative

Print name

(if you sign as a Personal/Legal Representative, please describe your authority to sign for the Patient.)

Date/Time

FOR GEISINGER USE ONLY

Patient refused to sign: _____

Reason signed Acknowledgment was not obtained: _____

Signature: _____ Title: _____ Date/Time: _____

¹ The term "Geisinger" shall refer to the entire health care system comprised of Geisinger Health ("GH") as parent and all subsidiary corporate entities. This form is approved for use at all Geisinger clinical entities.