Patient Privacy Notification Form

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Jennie Stuart Medical Group or any of its associates are unable to release any medical or billing information to anyone other than the patient without written consent by the patient.

Patient Name: ______________________________ Date of Birth: ____________________

Approved Communication Methods:

Is it ok to leave detailed messages on your voicemail? Yes / No Phone Number: ____________________

Is it ok to send text message reminders? Yes / No Phone Number: ____________________

Is it ok to send detailed information to your email? Yes / No Email Address: ____________________

Personal Representatives:

You have the right to authorize Jennie Stuart Medical Group to disclose or provide your protected health information, such as appointment and billing information and test results, to individuals of your choice who may act as your personal representative. As a designated personal representative, they may exercise your right to inspect, copy, and correct your personal health information. I understand the protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer by the responsibility of Jennie Stuart Medical Group. By listing individuals below, you are designating them as your Personal Representative and therefore access to all your medical and billing information.

◯ None – I opt out of designating a personal representative at this time.

Name of Personal Representative	Relationship	DOB	Phone Number

This authorization will remain in effect until terminated in writing by you, your personal representative or legal entity authorized to do so by court or law. You are not required to complete or sign this form. By declining to complete this form, Jennie Stuart Medical Group will not withhold services. Jennie Stuart Medical Group will be unable to discuss your medical or billing information to anyone other than you, to include spouses, parents, and children.

______________________________________ ____________________
Patient / Guardian Signature Date

______________________________________ ____________________
Guardian Printed Name Relationship to Patient