

SOUTH SHORE INFECTIOUS DISEASES & TRAVEL MEDICINE CONSULTANTS, P.C.

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Acknowledgement of Receipt of Notice of Privacy Practices

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices. We are legally required to give you this Notice of Privacy Practices and must obtain a signed statement that you received it. By signing this form, you are saying that you have received South Shore Infectious Diseases Notice of Privacy Practices.

South Shore Infectious Diseases Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

I _____ acknowledge receipt of the Notice of Privacy Practices for South Shore Infectious Diseases.

Signature of Patient or Personal Representative

Date

Relationship to Patient

Date

I give authorization for my health information to be discussed with:

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Information will NOT be disclosed unless the individual is listed above and the acknowledgement is signed by the patient.