PINNACLE FAMILY PRACTICE

13135 Lee Jackson Memorial Hwy #202 | Fairfax, VA 22033 | Phone 703-429-2901 | Fax 703-429-2902

Acknowledgement of Receipt of Notice of HIPAA/Privacy Practices

We are required by law to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy will be provided upon request.

I give my permission to download my medication list from my insurance (if available) YES ( ) NO ( )

I give my permission for PFP to view my prescriptions on the VA Rx Monitoring Program YES ( ) NO ( )

***Following questions asked by the government and require answers or they will fine medical practices**

Preferred language _____

Ethnicity (Check box): **( )** Hispanic or Latino
( ) Non-Hispanic or Latino
( ) or Decline to answer

Race (Check box): **( )** Alaskan Indian or American Indian
( ) Asian
( ) Native Hawaiian or other Pacific Islander
( ) Caucasian/European
( ) Black/African American
( ) Other _____
( ) Decline to answer

I acknowledge that I have received and read the Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction.

_____

Patient Name (Print) **Patient Date of Birth**

_____

Signature **Date Signed**

_____

Print Name of Person Completing form (if different from above) **Relationship to Patient**

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because: □ The Patient refused to sign □Due to an emergency situation, it was not possible to obtain an acknowledgement □We weren't able to communicate with the patient
□Other (details):_____

_____ _____

Employee Signature Date