PATIENT NAME: ______________________________

DATE: __/__/____

HIPAA DISCLOSURE ACKNOWLEDGEMENT

▢ **AURORA OFFICE**
14111 E. Alameda Avenue
Suite 200
Aurora, CO 80012
Phone: (303) 343-1357 | Fax: (303) 343-3036

▢ **THORNTON OFFICE**
8515 Pearl Street
Suite 100
Thornton, CO 80229
Phone: (303) 630-0400 | Fax: (303) 630-0405

It is the policy of all the clinics and providers at the location listed above to disclose your protected information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this acknowledgement.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (303) 343-1357. You have the right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, and health care operations. We are **not** required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.
The undersigned hereby acknowledges receipt of Notice of Health Information Privacy Practices:

Signature: ____ Date: ______/______/_________
If not signed by patient, please indicate relationship: ____

MAIL, EMAIL, VOICE MAIL, TEXTS AND PATIENT INFORMATION CONSENT

By signing below, I consent to be contacted by regular mail, by email or by telephone, regarding any matter related to the above referenced account by the creditor, its successors or assigns. This includes any updated or additional contact information that I may provide and include contact that employ auto-dialer technology and/or prerecorded messages.

In effort to protect your privacy, we have developed the following policy on leaving medical care messages and sharing patient information:

- We will **NOT** leave messages with anyone except the patient or legal guardian;
- We will **NOT** leave any confidential information on an answering machine;
- We will **NOT** leave any messages on a voice mail;

UNLESS, WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, ___________________________________ give Synergy Health Partners my permission to speak with and/or leave phone messages with the following. I fully understand that this consent will remain valid until revoked in **WRITING**.

My Home/ Cell answering machine: (_______) ___________ - ________________ Initials: _____________
(_______) ___________ - ________________ Initials: _____________
My Office/ Work voice mail: (_______) ___________ - ________________ Initials: _____________
My Spouse: ________________________ (_______) ___________ - ________________ Initials: _____________
My Guardian: ______________________ (_______) ___________ - ________________ Initials: _____________
Other: ______________________________ (_______) ___________ - ________________ Initials: _____________

Signature: ____ Date: ________/ _______/ _________