Harmony Community Clinic
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Acknowledgment of Privacy Practices and Communication Preferences

Health Insurance Portability and Accountability Act (HIPAA)

Patient name (print) _____ Date of birth _____ Date _____

1. Notice of Privacy Practices

Harmony Community Clinic's Notice of Privacy Practices describes how my health information may be used and disclosed for treatment, payment, and health care operations, and explains my rights, including the right to see and get a copy of my records, request corrections, request restrictions, receive an accounting of disclosures, and file a complaint.

☐ I received a copy of the Notice of Privacy Practices.

☐ I was offered a copy and declined it.

2. How the clinic may contact me

Check each method you allow. Standard email and text messages are not fully secure, and others may see messages on a shared device. By checking a box, I accept that risk for that method.

	Yes	No
Call my cell phone and leave a detailed voicemail	☐	☐
Call my home or other phone and leave a detailed voicemail	☐	☐
Text messages for appointment reminders	☐	☐
Text messages about test results, prescriptions, or my care	☐	☐
Email about appointments, billing, and my care	☐	☐
Clinic newsletters, promotions, and event announcements (optional)	☐	☐

Best phone number _____ Best email _____

3. People who may receive information about my care

I authorize Harmony Community Clinic to discuss my appointments, treatment, test results, and billing with the people listed below. I may change this list at any time in writing.

Name	Relationship	Phone	Information allowed (all / appointments only / billing only)

☐ Do not share my information with anyone except as required by law.

I understand my privacy rights and the communication preferences I selected above. _____ Initials

Signatures

By signing below, I confirm that I have read this form (or had it read to me) in a language I understand, that I had the opportunity to ask questions and all of my questions were answered, and that I agree to its terms voluntarily.

Patient name (print)	Patient signature	Date

Parent / guardian / legal representative (print, if applicable)	Relationship to patient	Representative signature	Date

Provider name and credentials	Provider signature	Date

Tell us about your visit

Your opinion helps other families find quality care. After your visit, scan this code with your phone camera to leave Harmony Community Clinic a review on Google.

Thank you for trusting us with your health.