

Notice of HIPPA Privacy Policy Practices Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the HIPPA Privacy Policy. By listing anyone on this form you give consent to VITA staff speaking to them regarding all of your private medical information.

I hereby give permission to all VITA staff to release any information about my medical condition, needs or status of my account to my designee(s), should it be necessary.

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Patient's Signature: _____ **Date:** _____

Witness: _____

_____ If you **decline** to designate anyone, VITA will not release information to any family member, friend, or legal representative.

IF individual received the HIPPA Notice of Privacy but did not sign, please list the reason why:

If individual did not receive the HIPPA Notice of Privacy, please explain why:

