SAINT LOUIS
Rheumatology
520 S. Elm Ave., St. Louis, MO 63119
Phone: 314.645.4434 Fax: 314.645.3801

ACKNOWLEDGMENT OF PRIVACY PRACTICES AND HIPAA DISCLOSURE AUTHORIZATION

Patient Name _____ **Date of Birth** _____

Receipt of Notice of Privacy Practices

Initial _____ I acknowledge I have received or I have been provided the opportunity to receive a copy of Saint Louis Rheumatology Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by Saint Louis Rheumatology.

HIPAA Disclosure Authorization(s)

I authorize Saint Louis Rheumatology to:

Initial _____ Contact me at the following number(s): _____

Initial _____ Leave a voice message with me at the following number(s): _____

Initial _____ Provide the following person(s) with my protected health information:

Print Name: _____

Relationship to Patient/Phone number: _____

Print Name: _____

Relationship to Patient/Phone number: _____

I do <u>not</u> authorize Saint Louis Rheumatology to:

Initial _____ Disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in Saint Louis Rheumatology Notice of Privacy Practices.

HIPAA Unencrypted Communication Authorizations

Electronic mail (email) and text messaging are common forms of communication, and can be utilized to communicate with your physician and your care team. It is important for you to understand that unencrypted email and text messaging are not secure communications. This means there is a potential risk that messages containing your protected health information may be intercepted by a third party. Encryption is the process of making information unreadable, unless you have the password or key to decrypt the information. Saint Louis Rheumatology does not encrypt text messages, and we cannot guarantee that all email messages will be encrypted.

By initialing below and signing this authorization, I understand and accept the conditions outlined above. I authorize Saint Louis Rheumatology to send unencrypted communications to the email address and/or phone number listed below.

I authorize Saint Louis Rheumatology to:

Initial _____ Send email to the following address: _____

Initial _____ Send text messages to the following phone number: _____

HIPAA Prescription Authorization(s)

Initial _____ I authorize Saint Louis Rheumatology to allow the following person(s) to pick up prescriptions on my behalf.

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any Saint Louis Rheumatology Provider.

_____ _____ / / _____

Patient Signature (or Patient Representative) Date Signed

_____

Relationship to Patient