Acknowledgement of Receipt of Privacy Practices Notice

Eastside Sports Rehabilitation Clinic

I have been presented with a copy of Eastside Sports Rehabilitation Clinic's **Notice of Privacy Practices,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: ___________________________________ **Date:** _______________________

Consent to Leave Messages

We at Eastside Sports Rehab are working hard to ensure that confidentiality regarding your Protected Health Information and treatment is maintained at all times. Due to confidentiality concerns and to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, we require your signature allowing us to leave a message about your upcoming office visit, account information, or any other information you may want us to convey to you via telephone or electronic messaging.

Please complete and sign this form, indicating your preference.

I, ______________________________, give Eastside Sports Rehab permission to:

- Leave a message regarding my upcoming office visit, account information, or other pertinent information on my answering machine.
  YES / NO
- Leave a message with someone who answers the phone at my residence.
  YES / NO
- Leave a message at my place of employment.
  YES / NO

Signed: ___________________________________ **Date:** ______________________