NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____ _____

Date Signature

DISCLOSURE AUTHORIZATION FORM
FAMILY AND FRIENDS

Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health of condition and related health care services ("**PHI**"). As required by the Health Insurance portability and Accountability Act of 19966 ("**HIPAA**"), Jeffrey Ridha MD PC has provided a Notice of Privacy Practices describing how it may use and disclose PHI. It is important to understand that any uses or disclosures outside those circumstances describes in the notice will be made **only with your written authorization including most disclosures to family members or friends.** This means we will not disclose information to a person despite their relationship with you unless you have specifically authorized them to receive such information. Therefore, this authorization must be completed to identify those individuals who will be permitted to receive information about your medical care.

AUTHORIZATION

I authorize the Practice to disclose my PHI to those individuals listed below (specify name, relationship and contact information if applicable:

Name	Relationship	Contact Number

The information that can be disclosed to the above names individuals includes:

- All PHI
- Only information relating to (specify such as appointments, payments, ect.):_____
- Other (specify):_____

This authorization will be in full force and effect for two years unless otherwise indicated below.

- Expiration Date: _____

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) **DATE**

_____

PRINTED NAME

Jeffrey R Ridha M.D., P.C.

PATIENT REQUEST FOR EMAIL COMMUNICATIONS

PATIENT: _____ **DOB**: _____

EMAIL: _____ **CONTACT #**: _____

Communications over the Internet and/or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicated via email.

Please be advised that: This request applies to Jeffrey Ridha MD, PC and/or associated staff.

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicate this day.
- I understand that all email communications in which I engage may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold Jeffrey Ridha M.D., P.C. and/or individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

PATIENT / GUARDIAN SIGNATURE	**DATE**
If personal representative, authority to act on behalf of patient	

IMPORTANT INFORMATION ABOUT PATIENT EMAIL

As a patient of Jeffrey Ridha M.D., P.C., you may request we communicate with you by electronic mail (email). This Fact Sheet will inform you about the risks of communicating with our office and how we will use and disclose provider/patient email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition.

If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you – and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and /or your phone have inherent privacy risks-especially when your email access id provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

Email messages may be inadvertently missed. Email is sent at the touch of a button. Once sent, and email message cannot be recalled or cancelled. Errors in transmissions, regardless of the sender's caution, can occur.

In order to forward or to process and respond to your email, associate staff may read your email message. Your email message is not a private communication between you and your treating provider.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

PLEASE RETAIN, THIS IS FOR YOUR RECORDS