

# HIPAA CONFIDENTIALITY AND PRIVACY FORM

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Office Manager at (919) 460-7676. All complaints must be submitted in writing within 180 days of the alleged violation. You will not be penalized for filing a complaint.

**Privacy Official Contact:** Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at 270 Cornerstone Drive, Suite 105, Cary, NC 27519 or (919) 460-7676.

**Please list your phone number(s):**

Phone \_\_\_\_\_ Type: cell home work

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I give Primary Medical Care permission to leave ANY information (including lab/test results, financial/insurance info, etc) on my voicemail.

I do NOT give Primary Medical Care authorization to leave any information on my voicemail other than stating to call my doctor's office.

I give Primary Medical Care permission to discuss any medical information (including lab reports, test results, financial/insurance information, etc) with the following people:

Name and Phone Number of Person(s) information may be shared with:

\_\_\_\_\_

Relationship to Patient (please circle which applies): spouse parent child sibling

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

**\*\*PLEASE COMPLETE TO UPDATE OUR RECORDS: Current Mailing Address (even if there is no change)**

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date \_\_\_\_\_

**\*\*Signature** \_\_\_\_\_

(If signature is not that of the Patient, indicate below the relationship of person to the Patient ( i.e. Parent, Family Member, Guardian, Close Relative or Guarantor)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Relationship to Patient)