Blairsville Internal Medicine

Mary Beth Wiles, MD Elizabeth Wiles, DO Jill Nielsen, DNP Suzanna Pollock, APRN

Patient _____ DOB _____ Chart _____

Privacy Practices Acknowledgement

I acknowledge that I have been made aware of the **Notice of Privacy Practices** for the Practices named below and that I have a right to receive a copy upon request. This **Notice** describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of the Practices' health care operations. The **Notice** also describes my rights and the duties of the Practices with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the Practices' registration area and on the Practices' web site. I may request that a copy be mailed to me by writing: Privacy Officer, PO Box 1000, Blairsville, GA 30514.

_____ _____

Signature of Patient, Legal Guardian or Health Care Proxy Date

How are we authorized to contact you?

Please check all that apply. At least one call method must be selected.

___ You may call my **HOME PHONE**	___ You may call my **CELL PHONE**	___ You may call my **WORK PHONE**
___ Leave call back number only	___ Leave call back number only	___ Leave call back number only
___ Okay to leave message	___ Okay to leave message	___ Okay to leave message

Choose how you wish to be contacted.

Health Notifications (labs, etc)	☐ Email*	☐ Text*	☐ Phone, as indicated above
Appointments	☐ Email*	☐ Text*	☐ Phone, as indicated above
Announcements	☐ Email*	☐ Text*	☐ Phone, as indicated above
Billing	☐ Email*	☐ Text*	☐ Phone, as indicated above

***Requires Portal registration. Please see Check In person, call 706-745-5541**

Is there someone you wish to name that you consent to receive medical and billing information about you?
☐ No, only me. Information about my treatment, medication, billing, etc. will be disclosed to ONLY me.
☐ Spouse/Partner ☐ I consent for Spouse/Partner to have Portal access. Please send invitation to his/her email

Email _____
☐ If other than Spouse/Partner, please complete the following:

Name _____ Relationship _____ Phone (_____)_____

☐ Consent for Portal access. Email _____

Name _____ Relationship _____ Phone (_____)_____

☐ Consent for Portal access. Email _____

I give my consent to be contacted in the manner(s) I have chosen above. If I have chosen my spouse or other person(s) to receive information on my behalf, I give my consent for them to receive information about me. If at any time I wish to change the manner by which I am contacted or the person(s) with whom you may share information, I am aware that I must notify the Practices in writing by completing a new consent form. This consent is valid until I provide the Practices a completed and signed new consent form.

_____ _____

Signature of Patient, Legal Guardian or Health Care Proxy Date