**HIPAA**

HIPAA refers to the Health Insurance Portability and Accessibility Act, a law enacted by Congress to attempt to guarantee that your health insurance will be available to you if you change jobs or insurance companies. HIPAA also assures that medical and personal information about you is kept confidential. This statement acknowledges that you understand this concept.

We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at [www.crisphealth.org](http://www.crisphealth.org).

**ACKNOWLEDGEMENT OF UNDERSTANDING OF PRIVACY PRACTICES**

**Marsha Seidelman, M.D., LLC**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand the Privacy Practices of Marsha Seidelman, M.D., LLC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

**VOICE MAIL MESSAGE AUTHORIZATION**

Please indicate below if you authorize employees of Marsha Seidelman, M.D., LLC to convey information about your health care to you or your representative via VOICE MAIL MESSAGE.

AT HOME/ON CELL: YES NO AT WORK: YES NO

IF YES, PLEASE CHECK APPROPRIATE LINE: IF YES, PLEASE CHECK APPROPRIATE LINE:

 Normal lab/test result notification only Normal lab/test result notification only

 A detailed message regarding results A detailed message regarding results

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

**DISCLOSURE TO FAMILY/FRIENDS**

\_\_\_\_\_\_\_\_ I do NOT permit Marsha Seidelman, M.D., LLC to disclose any information concerning my care or treatment to any individual without my express written consent or legal authorization.

\_\_\_\_\_\_\_\_ I authorize Marsha Seidelman, M.D., LLC to disclose information related to my care and treatment to the following named individuals:

Name/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_