Richmond Internal Medicine Group, P.C

HIPPA (Health Insurance Portability and Privacy Act) Acknowledgement

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I have been provided with the Notice of Privacy Practice for the office of **Richmond Internal Medicine Group P.C.** (Drs. Chacon, Perrone, Hanna) and understand my privacy rights as stated within.

Patient Print Name: _____

Patient Signature: _____

IF YOU ARE A MINOR, OR A PATIENT WHO COORDINATES HIS/HER CARE WITH A FAMILY MEMBER OR OTHER THIRD PARTY, PLEASE SEE AND SIGN BELOW:

I, _____ hereby authorize the person(s) listed below, access to my protected health information by phone, in person or in writing.

1. _____ _____ _____
(Name) **(Relationship)** **(Telephone Number)**

2. _____ _____ _____
(Name) **(Relationship)** **(Telephone Number)**

3. _____ _____ _____
(Name) **(Relationship)** **(Telephone Number)**

Please understand that we will not be able to release any information about your medical condition to anyone not authorized by you. It is your responsibility to change/update this information as necessary.

Patient Signature: _____ Date: _____