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HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received the Notice of Privacy Practices:

Signature_____Date _____

Print Name:_____

I give permission for telephone messages regarding protected health information to be left at the following numbers (check all that apply and write down applicable telephone number on the following line):

___Home Number (including answering machine):_____

___Work Number (including voice mail):_____

___Cell Number (including voice mail):_____

___Other Number:_____

Signature_____Date_____

By signing below, I give permission to **Foxhall Internists, PC** to discuss or release my Protected Health Information with the following persons:

Name:_____Relationship_____

Name:_____Relationship_____

Signature_____Date_____