Elizabeth M. Alexander, MD, a Washington Professional Limited Liability Corporation (PLLC)

Acknowledgement of receipt of Notice of Privacy Practices, and acknowledgement of several specific privacy issues

By my signature below, I, _____ acknowledge that I have reviewed the Notice of Privacy Practices for Elizabeth M. Alexander, MD, PLLC, posted on Dr. Alexander's website (ealexandermd.com).

I authorize Dr. Alexander or her assistant to leave voicemail messages concerning my health information (ie, lab results, appointment instructions, etc.) at the following number(s):_____

(optional) I designate the following individual(s) to receive communications from Dr. Alexander that may include health information about me: name: _____phone number: _____

(optional) Regular E-mail, as it goes over the internet, is not encrypted. I authorize Dr. Alexander's office to send e-mail appointment reminders, and non-sensitive information to the following email address:_____

I understand the following specific policies, and I have been given an opportunity to ask questions about them.

The law allows the doctor to disclose protected health information (PHI) without my written authorization in a variety of circumstances. The full Notice of Privacy Practices lists all such circumstances for which my consent is not required. Dr. Alexander wants be sure that I specifically understand that she is allowed (and sometimes required by law) to disclose protected health information in the following circumstances, whether or not I give my consent. **Please initial next to each item.**

_____ **To Avert a Serious Threat to Health and Safety:** I understand that Dr. Alexander may use and disclose health information about me, **WITHOUT MY CONSENT,** when, in her belief, such disclosure is necessary to prevent or lessen a serious threat to my health and safety or the health and safety of someone else, or the public. Dr. Alexander is required by law to report suspected abuse (by myself or any other person) of a child, elder or helpless person.

_____ **To Family and Friends who are involved with my care or payment for care:** I understand that, unless I object, Dr. Alexander or her agent may disclose health information about me to a family member or friend who is involved in my care or involved with payment related to my care when the information is directly related to their involvement. (In cases of a serious threat to health and safety, information may be disclosed even if I do object.)

_____ **On-the-job injury/illness claims:** I understand that Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims.

_____ **For Purposes related to Payment:** I understand that Dr. Alexander may use or disclose protected health information for purposes of receiving payment from my insurance or family member who is paying for care, unless I have already paid for the service in full and I request that no disclosure be made to insurance or guarantor family member.

_____ **Seriously overdue accounts.** I understand that seriously overdue accounts may be turned over to collections, and that this may result in the information about non-payment being forwarded to credit agencies.

_____ _____

Signature of patient (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name:_____

Relationship to Client: _____

For Office Use Only I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

* Individual refused to sign_____
* Communications barriers prohibited obtaining the acknowledgement_____
* An emergency situation prevented us from obtaining acknowledgement_____
* Other (Please Specify)_____

_____ _____

(Dr. Alexander signature—required only if client did not sign) date

A copy of this form will be retained in your medical record.