

Brian D. Jackson, DPM, LLC

HIPAA Acknowledgement

TELEPHONE PERMISSION

Where do you prefer to receive calls: (Please list the best number to reach you)

Home phone # Mobile #

Work phone # Extension #

Messages:

I agree to allow Dr. Brian Jackson / or a member of their staff to leave a message (please check all that are acceptable).

- On my answering machine.
With (specify name and relationship).
Exclusively with me.

Regarding:

- An appointment Referrals
Pending test results RX Information
Billing information Other

This document will be considered valid unless a written revocation is received.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

(Copy available at office or on our website)

I, hereby acknowledge the opportunity to read the Notice of Privacy Practices given to me by Brian D. Jackson, DPM, LLC.

Signed: Date:

FOR OFFICE ONLY:

If not signed, reason why acknowledgement was not obtained:

Person seeking acknowledgement: Date:

FOR OFFICE USE ONLY:

HIPPA Privacy Policy:

Has the patient acknowledged receipt of Brian D. Jackson, DPM, LLC's Privacy Policy? Yes

New Patient Information

Updated Information Date Updated Date Updated Date Updated