# Coastal Healthcare

**ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM**

1. **Acknowledgement of Privacy Practice Notice**
   I have received a copy of ***Coastal Healthcare's*** Notice of Privacy Practices.

   Patient name:_________________________________ Date of Birth___________

2. **I wish to be contacted in the following manner (check all that applies).**

   **Home/ Cell telephone #: __________________** Unless otherwise instructed a message with only the Doctor's name and number will be left.
   □ It is ok to leave a detailed message on my answering machine.

   **Work telephone #: ___________________** Unless otherwise instructed a message with only the Doctor's name and number will be left.
   □ Do not contact me at my work number.
   □ It is ok to leave a detailed message on my voice mail.

   **Written Communication** Unless otherwise instructed written communications will be mailed to the home address on file.

3. **Designation of Certain Relatives, Close Friends and Other Caregivers**
   I agree that ***Coastal Healthcare*** may disclose certain of my health information to a family member, close friend or other caregiver because such person is involved with my health care or payment relating to my healthcare. In that case, ***Coastal Healthcare*** will only disclose only information that is relevant to the person's involvement with my health care or payment relating to my health care.
   I designate the following person listed below as a person involved with my healthcare or payment relating to my healthcare for the purposes of ***Coastal Healthcare*** to make the type of disclosures listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

**Print Name (other than patient) 1)________________________ 2)__________________________**

**Relationship to Patient: 1)________________________ 2)__________________________**

**Date of Birth: 1)________________________ 2)__________________________**

**Telephone #: 1)_________________________ 2)__________________________**

___________________________________________ ___________________
Signature of Patient/Parent/Guardian Date