

Summit Medical Group

ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgment of Privacy Practice Notice

I have received a copy of the Summit Medical Group's Notice of Privacy Practices.

Patient's Name

Date of Birth

Signature of Patient/Parent/Guardian

Date

II. Designation of Certain Relatives, Close Friends and Other Caregivers

INITIAL

UPDATE

I agree that Summit Medical Group may disclose certain portions of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Summit Medical Group will *disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.*

I wish to make no designation at this time.

Signature of Patient /Parent/Guardian

Date

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Summit Medical Group's making the limited disclosures described above. (I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.)

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

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Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Print Name: _____ Last 4 Digits of His/Her SS # (required): _____

Signature of Patient /Parent/Guardian

Date

Please Return to Staff Member or Mail to: Summit Medical Group - HIPAA Coordinator , 1 Diamond Hill Rd, Berkeley Heights, NJ 07922