Shenandoah Pain & Palliative Care Clinic, LLC
173 E. Springbrook Road Broadway, VA 22815
(540) 901-7028

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Shenandoah Pain & Palliative Care Clinic, LLC is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

(Please check each box and sign.)

- ☐ I acknowledge that I have received a copy of Shenandoah Pain & Palliative Care Clinic, LLC HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
- ☐ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.
- ☐ I understand Shenandoah Pain & Palliative Care Clinic, LLC cannot disclose my health information other than as specified in the notice.
- ☐ I understand that Shenandoah Pain & Palliative Care Clinic, LLC reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address that I have provided.

_____ _____

Printed Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement
HIPAA Privacy Notice Acknowledgement

OFFICE USE ONLY

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s):

- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ The individual was unwilling to sign
- ☐ A communication barrier prevented us from obtaining the acknowledgement
- ☐ Other:_____

_____ _____

Staff Member Signature Date

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HIPAA Right of Access Form for Family Member/ Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:	**Relationship:**	**Phone #:**
_____	_____	_____
Name:	**Relationship:**	**Phone #:**
_____	_____	_____

Health Information to be disclosed upon the request of the person named above—(CHECK EITHER A OR B)

- ☐ **A.) Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR**
- ☐ **B.) Disclose my health record as above, BUT do not disclose the following (Check as appropriate):**
  - ☐ **Mental health records**
  - ☐ **Communicable diseases (including HIV and AIDS)**
  - ☐ **Alcohol/ drug abuse treatment**
  - ☐ **Other (please specify): _____**

This authorization shall be effective until (Check one):

- ☐ **All past, present and future periods, OR**
- ☐ **Date or event:_____,**

unless I revoke it. (NOTE: You may revoke this authorization in writing (preferably) at any time by notifying your health care providers.)

_____	_____
Printed name of the Individual Giving this Authorization	**Date of Birth**
_____	_____
Signature of the Individual Giving this Authorization	**Date**