

New Providence Internal Medicine Associates

Acknowledgment of Privacy Practice Notice And Designation of Disclosure

I. Acknowledgment of Privacy Practice Notice

I have received a copy of the New Providence Internal Medicine Associate'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

I agree that New Providence Internal Medicine Associates may disclose certain personal 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 health care. In that case, New Providence Internal Medicine Associates 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 designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of New Providence Internal Medicine Associate'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: _____

Print Name: _____

Print Name: _____

Print Name: _____

Print Name: _____

Signature of Patient/Parent/Guardian

Date