State of Franklin HEALTHCARE ASSOCIATES™

Acknowledgement of Notice of Privacy Practices

May we call the telephone number you have provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? ☐ Yes ☐ No

*If no, what other number *(i.e. cell phone, private work number)* may we try to reach you to leave a message?

_____ ☐ Cell phone ☐ Work ☐ Other: _____

May we mail your appointment or test results to your home address? ☐ Yes ☐ No

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Emergency Contact Number other than YOUR home phone number: *(Please note, you are giving permission for this emergency contact to receive your personal health information if necessary.)*

Name: _____ Phone Number: _____

I have been given the opportunity to review the **Notice of Privacy Practices** and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected health information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

	Name	Relationship	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

By signing below, I agree to the fore mentioned statements.

_____ _____ _____
Print Patient Name Cell Date of Birth

_____ _____
Patient or Guardian Signature Date

_____ _____
Practice Representative Signature Date

ACCESS YOUR MEDICAL INFORMATION ONLINE, 24/7 ANYWHERE, ANYTIME!

☐ **YES! I would like to enjoy the benefit of accessing my personal health information, or that of my child, online through FollowMyHealth® Email Address:** _____

☐ **Teaching Physicians:** This practice may participate in training new physicians. If so, you may be seen by a physician who is a member of a James H. Quillen College of Medicine Facility. The teaching physicians who work in this office are responsible for teaching residents (postgraduate trainees). Not only will you be seen by your own physician, you may also be seen by one or more residents. We believe this adds to the depth and level of care the patient receives since patients are seen by one or more physicians and then discussed in detail. We are pleased with your willingness to participate in our teaching program. Your care will encompass a team approach to healthcare with involvement of your physician and residents. Please Initial: _____