State of Franklin
HEALTHCARE ASSOCIATES

Acknowledgment of Notice of Privacy Practices

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.

I. May we contact you at any of the following numbers and leave a message on an answering machine or with a family member/friend regarding your appointment or test results (check all that apply)?

☐ Yes, cell phone: _____
☐ Yes, home phone: _____
☐ Yes, work phone: _____
☐ No

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

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II. Please provide the name of your Emergency Contact – telephone number should be different from yours.
Please note, you are giving permission for this contact to receive your personal health information.

Name:_____ Phone Number: _____

Is the person above also someone involved with your care that you would like for us to communicate with, if necessary?

☐ Yes ☐ No

Please provide the names of anyone else involved in your care that you would like for us to communicate with, if necessary. If none, please leave blank.

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

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

_____ _____ _____
Print Patient Name Cell Number Date of Birth

_____ _____
Patient/Parent or Guardian Signature Date

_____ _____
Practice Representative Signature Date

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Access Your Records Anytime

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

With FollowMyHealth, you can:

- Review your medical records online in a safe, secure environment
- Communicate privately with physicians via secure messaging
- View test and lab results
- Read medical notes from your doctor
- Request updates your health information (allergies, medications, conditions, etc.)
- Request Rx refills
- Request appointments
- Set up proxy accounts for children and dependent adults
- And more!

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

*If you would like to sign your child up for FollowMyHealth and they are between the ages of 14 and 17, please see the front desk. There is an additional form that you must complete in order to have access to their account.

☐ **Teaching Physicians and Other Medical Students:** This practice may participate in training new physicians, nurses, and other medical students. As a result, you may be seen by multiple individuals at one time, such as a nurse and trainee or your personal physician and 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 or nurses and then discussed in detail. We appreciate your willingness to participate in our teaching program. **Please Initial:** _____

By signing this form you are agreeing to participate in the Health Information Exchange or HIE, allows health care professionals to appropriately access and securely share your medical information electronically. This exchange helps your primary care provider, hospitals, specialists, etc. to avoid readmissions, avoid medical errors, improve diagnoses, and decrease duplicate testing records.

Please sign name: _____
Please print name: _____
Date of birth: _____