Date:_____

Name: _____

HIPAA ACKNOWLEDGEMENT FORM

I, **_____,** have received the Notice of Privacy Practices and I have been provided an opportunity to review it. With my consent, Oviedo Family Health Center may call my home or other designated location and leave a message on voice mail, answering machine or with family member. In reference to any items that assist the practice in carrying out TPO (treatment, payment and healthcare operations), such as appointment reminders, insurance items and calls pertaining to my medical care, including laboratory results, etc.

Release my information to: _____

CONSENT TO RECEIVE E-MAIL COMMUNICATION

I, **_____**, hereby give consent to Dr Patel and/or Nurse Practitioner Graves or their designated staff to send me laboratory or other test results, or other protected health information via a secure portal associated with the email address below:

E-Mail address:

- I have been notified that this patient portal is secure. .
- I will have a password to unlock the information contained in the patient portal.
- **I am aware that I will receive my results via patient portal and will not receive a phone call if signed up for the portal, unless specifically requested by me. I am always free to discuss my results with the providers via the portal or by phone call once the results have been received.**
- I am aware that once I receive this e-mail information, it is my responsibility to keep the contained information confidential, and after I receive my personal information, that Oviedo Family Health Center is no longer responsible for the security of the transmitted information

O·F·H·C

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Signature of Patient or Guardian