MN ANGELS CLINIC
GEORGES T. JABALY, M.D

I, _____hereby acknowledge receipt of "Notice of Privacy Practices and Patient Right and Responsibilities from MN Angels Clinic."

In general, **HIPAA** privacy rule gives individual the right to request a restriction on uses and disclosure of their protected health information **(PHI)**. The individual is also provided the right to request confidential communications or that a communication of protected health information be make by alternative means, such as sending correspondence to the individuals office instead of the individuals home.

I wish to be contacted in the following manner (check all that applies):

Oral communication (Please check one):

- Home Telephone:_____ Work Telephone:_____
- Ok to leave a message with detailed information. - Ok to leave a message with detailed info.
- Leave a message with call back number. - Leave a message with call back number.
- Other:_____ - Other:_____

Written communication (please check all that applies):

- Ok to mail personal health info to my home - Ok to leave message with detailed info.
- Ok to mail to my work address - Other
- I permit the practice to discuss my PHI with, and to disclose my PHI to, the following individuals:
- Spouse:_____
- Adult, Child(ren):_____
- Personal representative:_____
- Other:_____
  _____
  _____

_____
Signature Date