TOMAGWA
HealthCare Ministries
Neighbors Caring About Neighbors

HIPAA DISCLOSURE
ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed of TOMAGWA'S Notice of Privacy Practices and the complete description of the uses and disclosures of my health information. I have reviewed this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

RELEASE OF INFORMATION AUTHORIZATION

_____ TOMAGWA **MAY NOT** discuss my healthcare and may not discuss and/or make financial arrangements with anyone.

_____ TOMAGWA **MAY** discuss my healthcare, and/or make financial arrangements and allow medication pickup with only the following individuals:

Name:_____Relationship:_____ Phone: _____

Name:_____Relationship:_____ Phone: _____

Name:_____Relationship:_____ Phone: _____

EMERGENCY CONTACT

Name:_____ Relationship:_____Phone:_____

PREFERENCES

I prefer to be contacted in the following manner:

Phone #: _____ Email:_____

_____Leave Message with detailed information.
_____Leave Message with contact information only.
_____DO NOT leave a message.

I hereby consent to medical services and treatment from the physicians and staff of TOMAGWA HealthCare Ministries. I authorize TOMAGWA to release any and all information to consulting physicians.
I understand that payment for all services is my responsibility.

Signature of Patient or Responsible Party (Parent/Guardian) and relationship Date

Print name:_____**Date of Birth:**_____