RESIDENTIAL MEDICAL KARE, LLC
HIPAA Acknowledgement & Release Form

Notice of Privacy Practices

Name of Patient _____ Date of Birth _____

Residential Medical Kare, LLC, is required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices concerning protected health information. I, hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Release of Information:

Please let us know how your personal health information may be released

☐I am the only one who should receive information regarding my personal health information (PHI).

Best way to contact me:

☐ Home phone _____ Permission to leave a message Y ☐N☐

☐ Cell Phone _____ Permission to leave a message Y ☐N☐

I, authorize the release of my medical information including diagnosis, records, medical examinations rendered to me, and claims information. This information may be released to:

☐Spouse _____

☐Child(ren) _____

☐Other _____

Signed: _____ Date _____

Residential Medical Kare, LLC

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