



# MEMPHIS MUSLIM MEDICAL CLINIC

a project of

Memphis Muslim Medical Services, Inc.

1055 Stratford Road, Memphis, TN 38122 • Phone: (901) 685-3901 • Fax: (901) 685-3903

www.muslimclinic.org

## HIPPA ACKNOWLEDGMENT AND CONTACTS

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MRN: \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, \_\_\_\_\_ (Patient or Representative), hereby acknowledge receipt of the "Notice of Privacy Practices" given to me by Memphis Muslim Medical Clinic, and I have read and understood the policy outlined therein.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### CONTACT INFORMATION

Please let us know how we may contact you with appointment reminders/changes, test results or other personal information regarding your medical care:

- 1) Please print your preferred phone number and whether this is a home or cell number: \_\_\_\_\_
- 2) Please list your email address: \_\_\_\_\_
- 3) May we leave messages regarding confidential matters on your answering machine or voice mail? Y/N
- 4) May we send text and/or email messages regarding appointment reminders or other reminders? Y/N

### AUTHORIZED PERSONS UNDER NORMAL CIRCUMSTANCES

Please list the family members or other persons, if any, that we may inform about your medical condition, diagnosis, treatment, account information, or any other information relevant to your medical care.

NAME

RELATIONSHIP

CONTACT NUMBER & EMAIL

### AUTHORIZED PERSONS IN AN EMERGENCY

Please list the family members or other persons, if any, that we may inform about your medical condition, diagnosis, treatment, account information, or any other information relevant to your medical care ONLY IN AN EMERGENCY:

NAME

RELATIONSHIP

CONTACT NUMBER & EMAIL

### DOCUMENTATION OF GOOD FAITH EFFORTS

(This Section to be filled by Office Staff only)

The patient, \_\_\_\_\_, was provided a copy of our, "Notice of Privacy Practices." A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgement could not be obtained because:

- Patient refused to sign because \_\_\_\_\_
- Patient/Responsible party was unable to sign/initial because \_\_\_\_\_
- Acknowledgment delayed due to Medical Emergency, and will be attempted at the next available opportunity.

Name of Employee completing form: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The information on this form will be used permanently unless we are notified in writing of any changes**