



HIPAA FORM

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Ennis, TX 75119**

Acknowledgement of Receipt of Notice of Privacy Practices:

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health conditions. I understand that Omega Rehabilitation & Spine reserves the right to change their Notice of Privacy Practices. I may request a copy of the updated Notice of Private Practices by calling my physician's office or requesting a copy in person at my appointment.

_____ I want a copy

_____ I do not want a copy

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I gave permission for Omega Rehabilitation & Spine to share my protected health information with:

1. Name: _____ Relationship: _____

Phone: _____ Contact's DOB: _____ (required for identification purposes only)

2. Name: _____ Relationship: _____

Phone: _____ Contact's DOB: _____ (required for identification purposes only)

Patient Printed Name

Date of Birth

Signature of Patient, Parent or Legal Guardian

Date

Relationship to Patient

Telephone Contact:

May we leave messages on your answering machine regarding your care? _____ Yes _____ No

(Please understand that if we cannot leave messages, it will be your responsibility to initiate contact with us regarding follow up of test, appointments, etc.)

Signature of Patient, Parent or Legal Guardian

Date