ARETE PROVIDER NETWORK
Arete Family Medicine - Anchorage

Notice of Privacy Practices for Protected Health Information

I, _____ acknowledge I have been offered a copy of Arete Family Medicine - Anchorage's HIPAA policy.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Please list any emergency contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I authorize access and disclosure of my Protected Health Information (PHI) to the following individuals:

Name: _____ Relationship: _____ DoB: _____
Information type: ☐ Billing ☐ Medical ☐ Scheduling

Name: _____ Relationship: _____ DoB: _____
Information type: ☐ Billing ☐ Medical ☐ Scheduling