

**UNITY Healthcare**  
**Notice of Privacy Practices for Protected Health Information**  
**Acknowledgement of Receipt of Notice of Privacy Practices**

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Request for Limitations and Restrictions of Protected Health Information** (This only pertains to how our office communicates with you.) PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

It is the office policy of Ravish J. Mahajan, M.D., and staff not to release confidential and/or unauthorized information. When returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence, unless permission is granted as shown below. Information also will not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following (We can reach you in an emergency, if we have your cell phone number):

I hereby authorize Ravish J. Mahajan, M.D., and/or his staff, to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the doctor's office whenever this information changes:

			<u>Phone Number</u>
Home Telephone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Answering Machine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Work Telephone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Voice Mail:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cell Phone and/or mail:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pager:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

**Please list the names of authorized people:**

Spouse: \_\_\_\_\_  
Parent: \_\_\_\_\_  
Other (please list name & relationship): \_\_\_\_\_  
Other (please list name & relationship): \_\_\_\_\_

**SIGNATURE OF PATIENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**FINANCIAL INTEREST DISCLOSURE**

Unity Healthcare, LLC ("Unity") holds an investment interest in certain bonds which were issued for financing health care facilities of St. Elizabeth Regional Health. St. Elizabeth Regional Health is owned and operated by the Sisters of St. Francis Health Services, Inc ("SSFHS"). You are free to determine which facility to utilize for health care services and neither Unity nor your physician will discriminate in the care provided to you should you desire to use a non-SSFHS facility. Please acknowledge your receipt of this disclosure by signing below.

By: \_\_\_\_\_ Relation to pt: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, or in case of minor, patient's guardian