Winchester Endocrinology
172 Linden Drive, Suite 107 • Winchester, VA 22601
(540) 678-0767
www.winendocrine.com

Patient Name _____ Chart Number: _____

On this date, you have been given a notice describing how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This notice is required by the Privacy Regulations created as a result of the health Insurance Portibility and Accountability Act of 1996 (HIPAA).

I hereby acknowledge that I have been given a copy of Winchester Endocrinology's Notice of privacy practice.

_____ _____
Date Patient's Signature

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request how our office may communicate with the patient regarding appointments, test results, etc.

I wish to be contacted in the following manner (check all that apply):

Home telephone (____) _____

- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with the call-back number only

Work telephone (____) _____

- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with the call-back number only

Cell phone (____) _____

- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with the call-back number only

_____ _____
Date Patient's Signature

Please provide names if any to whom we can give Medical Information to: