Germantown Psychological Associates, P.C.

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Psychologists
Richard L. Luscomb, Ph.D.
Joseph C. Angelillo, Ph.D.
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Roy D. Greenberg, Ph.D.
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Brian D. Bruijn, Ph.D.
Brittany A. Kinman, Ph.D.

Protected Health Information Acknowledgment Form

Clinical Social Worker
Karen D. Sanders, LCSW
Julie H. Ferguson, LCSW

Medical Consultant
Jeffrey H. Lowrey, M.D.

Clinician: RLL JCA RDC RDG KDS ALA JHF BDB BAK

Patient Name:___________________________

GPA ACCOUNT #: ____________________

You should review the **Notice of Privacy Practices** regarding Germantown Psychological Associates, P.C.'s Policies and Practices to Protect the Privacy of your health information **prior to signing this sheet**.

May the GPA, PC staff leave messages regarding your health care on your HOME voicemail or answering machine?
▢ **YES** ▢ **NO**

May the GPA, PC staff leave messages regarding your health care on your CELL PHONE voicemail and TEXT? [At some time in the future, this may include notification/reminder of upcoming appointments]. NOTE: **TEXT is not encrypted and thus, is not a HIPAA secure form of communication.**
▢ **YES** ▢ **NO**

May GPA, PC clinicians communicate with you regarding health care issues through your E-Mail. NOTE: E-Mail is not encrypted and thus, is not a HIPAA secure form of communication. Your E-Mail address will not be shared with any other practice, clinic or person outside of GPA, PC.
▢ **YES** ▢ **NO**

E-Mail Address: _________________________@____________________ Who has access to this E-Mail? ________________

Individuals to whom information may be disclosed in the event Germantown Psychological Associates, P.C. cannot reach you - information regarding appointments may be discussed and/or released to:

Name of Person: ____ Relationship to Patient: ___________________________________

Home Phone: [ ] ____________________ Cell Phone: [ ] ____________________ Work Phone: [ ] ____________________

Name of Person: ____ Relationship to Patient: ___________________________________

Home Phone: [ ] ____________________ Cell Phone: [ ] ____________________ Work Phone: [ ] ____________________

I hereby acknowledge that I have reviewed the **Notice of Germantown Psychological Associates, P.C. Policies and Practices to Protect the Privacy of Your Health Information** as well as the above consent information contained on this form and give my permission to GPA, PC to use and disclose my health information in accordance with it:

Print **Patient's Full Name**: ____

Signature of Patient [or Parent if Minor Child]: ____________________________________ Date: ________________

Print Parent Name if Minor Child: ____

Signature of Witness [GPA Staff Member]: ____ Date: __________________