Essential Rheumatology LLC
860-325-6908

HIPAA Notice of Privacy Practices & PHI Disclosure

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been provided access to the Notice of Privacy Practices for Essential Rheumatology LLC, which outlines how my Protected Health Information (PHI) may be used and disclosed under federal law.

Authorized Disclosures (Optional Family/Caregiver Access)

I authorize the clinical and administrative staff of Essential Rheumatology LLC to discuss my medical condition, laboratory results, appointments, and billing information with the following designated individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Communication Preferences

I authorize the practice to leave detailed medical or billing messages on my confidential voicemail at the phone number provided in my registration demographics.

☐ **Yes, detailed messages allowed.**

☐ **No, urgent call-back requests only.**

Acknowledgment

☐ **I acknowledge the privacy practices and confirm my communication choices.**

_____

Patient Name (Print) Patient Signature

_____

Date