Integrity Hospice & Palliative

Notice of Privacy Practices Acknowledgment & Permitted Individuals Involved in Your Care

I, *(Print Client Name)* _____, acknowledge that Integrity Hospice & Palliative has provided me a copy and I have received a copy of their **Notice of Privacy Practices (rev. 9/2013)**.

Client or Legal Guardian Signature _____ Date _____

Permitted Individuals Involved in Your Care

During the provision of your medical care, it may be necessary for Integrity Hospice & Palliative staff to communicate with your family members or other individuals involved in your care. To assist us in identifying appropriate individuals, we ask that you provide information regarding people to whom we may communicate:

	Permitted Individual #1	Permitted Individual #2	Permitted Individual #3
Name			
Address			
City, State, Zip			
Phone			
Relationship			
Type of Information *(Health, Financial, All)*			

For Staff Use Only

Vision Entry Date: _____ Effective Date: _____

If acknowledgment not obtained, reason for absence _____

Staff Name Printed _____ Staff Signature _____ Date _____

Routing Instructions

All Divisions: Once uploaded in Vision (Census/Patient Info/Attachments), form is filed in client chart
Clients w/ multiple service lines: If no changes to contacts, form not required.
Clients w/ changes to approved contacts: Follow certified or hourly procedure.