Advanced Rheumatology & Arthritis Center
Jim C. Kim, MD
2203 17th Street
Bakersfield, CA 93301
(661) 716-0333 Fax (661) 716-1288

Patient Name _____Email Address:_____Birthdate _____
(Please Print)

HIPAA PRIVACY DISCLOSURES AND RESTRICTIONS

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

Home Phone _____ Work Phone _____ Cell Phone_____

☐ OK to leave message at home	☐ OK to leave message at work	☐ OK to leave message on Cell
☐ Do not leave message	☐ Do not leave message	☐ Do not leave message
☐ Do not call at home	☐ Do not call at work	☐ Do not call Cell

Written Communication:

☐ OK to mail to my home address ☐ Do not mail to my home address

☐ OK to email medical related information

☐ Other _____

Signature _____ Date _____

PRIVACY PRACTICES DOCUMENTATION

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature _____ Date _____

To Be Completed by Front Office

Written acknowledgment could not be documented due to:

☐ Patient refused to sign

☐ Personal representative not available to sign

☐ Language, communication, or effects of disability impeded acknowledgment

☐ Other, please specify _____