GIL R VILLANUEVA, MD PA
1162 E SONTERRA SUITE 110
SAN ANTONIO, TEXAS 78258

HIPAA Notice of Privacy Practices Acknowledgment and Questionnaire

Please list family members or other persons, if any, whom we may inform about your general medical condition, your diagnosis, and any billing questions (including treatment, payment, and healthcare operations). **As a reminder, these will be the only people we will be able to speak to or release any information to regarding your account.**

Name:______________________________________ Phone#_____________________

Name:______________________________________ Phone#_____________________

Name:______________________________________ Phone#_____________________

Name:______________________________________ Phone#_____________________

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

NO__________ Yes__________ Phone#_____________________

Please indicate if we may mail your appointment postcard via mail:

NO__________ Yes__________ Address:_____________________________________

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By signing this form, I freely consent to the use and disclosure of protected health information about me for the purpose of treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

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Patient Signature Date