401 W Martintown Rd, Suite 153 · North Augusta · SC · 29841 · 803-693-5514

HIPAA PRIVACY PRACTICES ACKNOWLEDGMENT & COMMUNICATION CONSENT

This form is intended as a patient-facing acknowledgment and communication authorization. It should be reviewed against Taylor's Compounding's current Notice of Privacy Practices and applicable federal/state requirements before implementation.

PATIENT INFORMATION

Patient Name:	Date of Birth:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been offered or provided access to Taylor's Compounding's Notice of Privacy Practices, which explains how my protected health information (PHI) may be used and disclosed and describes my privacy rights. I understand that I may request a paper copy of the Notice at any time.

Patient/Personal Representative Signature:	Date: _____

COMMUNICATION PREFERENCES

I authorize Taylor's Compounding to contact me regarding prescriptions, refills, consultations, laboratory information, billing, pickup/shipping, and other pharmacy-related matters using the methods I select below:

☐ Phone call	☐ Voicemail	☐ Text message/SMS
☐ Email	☐ Patient portal/secure message	☐ Mail
Preferred phone:	Preferred email:	
May leave a detailed voicemail? ☐ Yes ☐ No	May send messages that identify Taylor's Compounding? ☐ Yes ☐ No	

Electronic communications may carry privacy risks depending on your device, carrier, email provider, and security settings. You may change these preferences by notifying the pharmacy.

AUTHORIZED PERSON(S)

I authorize the pharmacy to discuss my prescription and health information with the following person(s), subject to the limits I indicate:

Name	Relationship	Phone	Information permitted
			☐ All ☐ Pickup/payment only ☐ Other
			☐ All ☐ Pickup/payment only ☐ Other

PATIENT RIGHTS & REVOCATION

I understand that I may revoke a communication authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that signing this communication authorization is voluntary and that treatment or payment will not be conditioned on authorizing optional communications or disclosures, except as permitted by law.

Patient/Personal Representative Signature:	Date: _____
If representative, relationship/authority:	Staff initials: _____

For office use if acknowledgment is not obtained: ☐ Patient declined to sign ☐ Patient unable to sign ☐ Other: _____ Staff/Date: _____