

HIPAA Notice and Acknowledgment

Acknowledgment:

I acknowledge that I have been offered/received the Notice of Privacy Practices.

Signature _____

Date _____

List any person(s) you would like for us to share your medical information with. This includes balances, appointments, insurance questions, medical information, etc.

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby authorize my healthcare professional to evaluate and render treatment to me. This authorization will be effective until revoked in writing by me or my legal representative.

I authorize my physician, or employees and/or agents to discuss my medical/billing information with me/my spouse/next of kin/or caregiver. I authorize use of a telephone appointment reminder system. I give prior express consent to contact me by sending text messages (which could result in charges to me from my carrier) or e-mails, using any e-mail address or cell phone number, for the purpose of treatment, insurance, appointments, and/or payment.

I have been made aware and understand that the physicians/nurses may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I authorize the release of any medical or other information necessary to process my medical claims. I also request payment of government benefits either to myself or to the party who accepts assignment below. If my health information includes substance use disorder records, I authorize the use and disclosure of that information for treatment, payment and healthcare operations.

I authorize payment of medical benefits to the undersigned physician or supplier for services described on my medical claim.

Signature _____

Date _____