MEDICAL INFORMATION RELEASE FORM – HIPAA

NAME:_____ DATE OF BIRTH: ____/____/____

I authorize the release of information including diagnosis, records, examinations, etc. rendered to me and claims information to the following:

[ ] The information may not be released to anyone

[ ]_____

[ ]_____

Patient Signature: _____ Date:_____

MESSAGES

I, _____, hereby consent and state my preference to have my chiropractor, Edie Spence, and other staff at Appalachian Natural Health Center communicate with me regarding my appointments by email and /or standard SMS/text messaging. I understand that email and SMS/text messaging is not confidential method of communication and therefore there is a risk that appointment information might be read by a third party. I also consent that all other aspect s of my health care (test results, billing, etc.) may be communicated via a personal telephone call – including voicemail. If I decide to initiate contact with the office via Facebook or other similar platform, I accept the risks using an unencrypted non-HIPAA compliant means of communication.

I give my permission to leave my private health information (via a phone call/voicemail) and appointment reminders (via email and/or text message) and occasional health and office related newsletters (via email) at the following:

PLEASE CHECK AND FILL OUT ALL THAT APPLY –

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

EMAIL: _____

Please tell us the preferred phone number for us to contact you: _____

I attest that I have read the above information on messages.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand that this form will be placed in my chart and maintained between one and three years.

Patient Signature: _____ Date: _____