MEDICAL INFORMATION RELEASE FORM – HIPAA

Name: _____ Date of Birth: ____/_____/_____

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

[ ] The information may not be released to anyone.

[ ] _____ [ ] APPOINTMENT ONLY
[ ] _____ [ ] APPOINTMENT ONLY
[ ]_____ [ ] APPOINTMENT ONLY

MESSAGES

I, _____, hereby consent and state my preference to have my
Patient Name
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 a 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 aspects of my health care (test results, billing, etc.) may be communicated via a personal telephone call – including voicemail.

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

Please check and fill out ALL that apply-

HOME PHONE: _____
CELL PHONE: _____
TEXT:_____
WORK PHONE: _____
EMAIL: _____

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

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: ___/___/___