

Advanced Relief Chiropractic & Acupuncture

Contact Information:

In general, the HIPAA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____
 O.K. to leave a detailed message
 Call Back Number ONLY

Written Communication
 O.K. to mail to home address

Work Telephone _____
 O.K. to leave a detailed message
 Call Back Number ONLY

Other _____

Patient Name

Patient Signature

Witness

Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests to PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to users or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Authorization to release information as indicated: (check the appropriate blank)

My Health Care Information

1. ___ I authorize disclosures of health information (related to my medical history, diagnosis, treatment or prognosis) to all inquiries or only to the following people or entities (for example: family, friends, employer, insurance companies, clergy, etc.)

List Names: _____

Limited Health Care Information

2. ___ I wish to limit disclosure of only certain kinds of health care information (relating to my medical history, diagnosis, treatment, or prognosis) to the following people or entities:

List Names

List information to be released

No Information

3. ___ I do not authorize release of information regarding my healthcare, diagnosis, prognosis, and/or treatment. I wish to be a "no information" patient, and I realize that nobody will be allowed to obtain any information relating to my medical history, diagnosis, treatment, and/or prognosis.

I am 100 percent responsible for all payments.

Patient Name

Patient Signature

Witness

Date