

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Active Chiropractic's *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name (print)

Patient's Date of Birth

Patient Signature

Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____

(Print)

Date

Signature of Personal Representative: _____

Relationship to Patient: _____

Drivers License Number: _____

State _____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the *Notice of Privacy Practices*:

Attempt 1: _____ Date _____ Staff: _____

Attempt 2: _____ Date _____ Staff: _____

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Active Chiropractic disclosure of my individually identifiable health information to the individuals listed:

1. Name _____ Relationship to Patient _____

Authorization to:

- Disclose treatment plans and test results
- Billing information including statement balances
- Past and future Appointments
- Receive phone messages and/or email regarding appointments or test results
- Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- Disclose treatment plans and test results
- Billing information including statement balances
- Past and Future Appointments
- Receive Phone Messages or email regarding appointments or test results
- Other _____

We have permission to (please check all that apply):

- Leave messages on home phone or with household members
- Leave messages on work phone
- Leave messages on cell phone
- Confirm appointments by phone or text
- Send emails that may include Protected Health Information, or surveys via encrypted email

This authorization is effective through (check one):

- ____/____/____
- NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Active Chiropractic in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Active Chiropractic until the termination request is received in writing and processed.

Authorization to Disclose:

Patient Name (print)

Patient's Date of Birth

Patient Signature

Date

Signature of Personal Representative

Date

Relationship to Patient: _____ Drivers License Number: _____ State _____