HIPAA Acknowledgement & Release Form

Notice of Privacy Practices

Print Name of Patient: _____ Date of Birth: _____

We, at Bradham Chiropractic Clinic, are required by law to maintain the privacy of and provide individuals with access to the Notice of our legal duties and privacy practices with respect to protected health information. *I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practices document and understand that I may obtain a copy for my records upon request.*

Release of Information

Please let us know how your personal health information may be released:

☐ I am the only one should receive information regarding my personal health information.

or

☐ I, _____, authorize the release of my medical information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

Best Way to Contact Me

☐ Cell phone _____

Permission to leave a message? Y N

Permission to text? Y N

☐ Home Phone _____

Permission to leave a message? Y N

☐ Other (please specify) _____

Patient Signature: _____ Date _____

Authorized Representative (if not patient): _____ Date _____

Relationship to Patient: _____

Witness: _____ Date _____