

# Acupuncture & Skin Rejuvenation Center

Helping you feel and look your best... from the inside out!



Fran Ammons, LAc

## Notice of Patient Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

A complete, detailed copy of HIPAA is available to read in our lobby. If you wish to take a copy for your records please ask the receptionist and they would be glad to assist you.

## Authorization to use and disclose your protected health information for a special purpose

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize my Protected Health Information to be used or disclosed for:

Yes	No	Situation
		Health Insurance Claim Processing
		Updating my primary care physician
		Leaving test results on my answering machine
		Leaving appointment reminders on my answering machine
		Leaving billing messages on my answering machine
		Leaving messages via email. Email address:

I authorize the following people to receive my protected health information:

(Examples include another doctor besides your primary care physician, your spouse, another family member)


I understand that if my health information is disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that my revocation is not effective to the extent that the persons I have authorized to use and or disclose my protected health information have acted in reliance on this authorization.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. However, I understand I will be responsible to pay for my medical care in full and file claims myself if I refuse disclosure to my health insurance company.

I have had the chance to read the content of this authorization form and I agree with all statements made herein. I give this authorization voluntarily.

This authorization expires one year from date below unless revoked.

Signature of patient or patient's personal representative

Relationship to patient

Date: \_\_\_\_\_

**You Have A Right To A Copy Of This Form After You Sign It – Please Ask And One Will Be Created**