HIPAA Acknowledgement & Appointment Reminders Form

I acknowledge that Jessica Clayton, D.Ac, L.Ac has provided me with a "Notice of Privacy Practices." I understand that I have a right to review Jessica Clayton's "Notice of Privacy Practices prior to signing this document. The "Notice of Privacy Practices Center is also provided on request.

Members of the staff may need to contact you with appointment reminders or information related to your treatment. If this contact is made by phone and you are not home, a message will be left on your answering machine or with whoever answers the phone. If this contact is made by email it will not be sent by secure email. By signing this form you are giving us authorization to contact you with these reminders and information.

____

Patient Name (Printed) Date

____

Patient Signature

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (OPTIONAL)

I, ____________________________________, hereby authorize Jessica Clayton, D.Ac, L.Ac to use or disclose of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive my information is not a health insurance plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Person's Organizations authorized to receive information: (please print)

1. ______________________________ 3.______________________________

2. ______________________________ 4.______________________________

______________________________ ______________________________

Patient Signature Date

Jessica Clayton, D.Ac, L.Ac
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