ENGLANDER CHIROPRACTIC CENTER
PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the Englander Chiropractic Center *Notice of Privacy Practices for Protected Health Information.*

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that…

I may be contacted by: Phone at home or work, mobile phone, e-mail, or postcard.
Messages may be left: On answering machine/voicemail at home, work, and on mobile phone.
Or with individuals answering my phone at home, or work.
(Please place a line through any method that you refuse to be contacted by and initial.)

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

________________________ ________________________
Patient Name Printed Date

________________________ ________________________
Patient Signature Authorized Provider Rep.

________________________ ________________________
Personal Representative Printed Personal Rep. Signature

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Description of personal representative's authority to act for the patient

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