HIPAA & Appointment Reminder Acknowledgement Form

I acknowledge that I have been provided access to the TPAIM "Notice of Privacy Practices". I understand that I have the right to review the "Notice of Privacy Practices" prior to signing this document.

I understand that TPAIM may need to contact me with appointment reminders or information related to my treatments. This contact may be made by phone or email. If this contact is to be made by phone, and I am not at home, a message will be left on my phone or answering machine voicemail or with anyone who answers the phone.

I understand that my clinical information may be used for research and/or educational purposes by TPAIM or individuals authorized by TPAIM. All information identifying me personally will be removed.

By signing this form, I am giving TPAIM authorization to contact me with these reminders and to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at TPAIM will be held confidential except in the instance where my safety or the safety of others may be at risk.

Patient Name (Print) _____

Patient Signature: _____ Date: _____

TPAIM Privacy Rep/Date: _____

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Two Pines Acupuncture & Integrative Medicine the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____

_____

_____

_____

Patient's Signature: _____ Date: _____