Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Printed Name: _____ Signed: _____

Date: _____ Telephone: _____

If not signed by the patient, please indicate.
Relationship:
- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficially or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:
- ☐ Signed form received by: _____

Authorization for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 TOEWS CHIROPRACTIC, P.C. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the use / disclosure / use and disclosure of the following health information that pertains to me:
All health information contained in your patient records and billing obtained from your treatments for the following purpose<s>.
1. To send records/documents to another health care provider or your insurance provider/plan.
2. For payment / reimbursement.
3. Workers compensation claims.
4. Any person listed below.

I authorize the following persons to make these disclosures of my health information: Mark A. Toews, D.C.

I authorize the following persons to receive these disclosures of my health information:
1.
2.
3.
4.
I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Toews Chiropractic Clinic. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire _____.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Signature: _____ Date: _____

REVOCATION SECTION: I hereby revoke this authorization.

Signature: _____ Date: _____

TOEWS CHIROPRACTIC, P.C., Mark A. Toews, D.C., 1225 N. Perkins Road Suite A, Stillwater, OK 74075, 405-372-3733

Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, _____ (*print name*) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

☐ **Phone** I want you to contact me by telephone at _____

☐ Do ☐ Do not leave messages on my answering machine. ☐ Do ☐ Do not leave messages with any other person.

☐ **Mail** I want you to contact me at the following address: _____

Other requests for confidential communications (specify). _____

Print Name: _____ Signed: _____ Date: _____

If not signed by the patient, please indicate: Relationship: ☐ parent or guardian of minor patient ☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient ☐ other (specify)

Name of Patient: _____

For office use only:

Date Granted: _____ **Date Terminated or Modified:** _____

Request for Special Privacy Protections

As required by the Health Information Portability and Accountability Act of 1996, you have a right to request that we restrict our uses and disclosures of your protected health information with respect to treatment, payment and health care operations. You also have a right to request that we restrict our uses and disclosures of your health information with respect to disclosures to members of your family and other relatives or close personal friends or other person you identity who are involved in your care or payment for your care, or to notify or assist in notifying those individuals of your location, general condition or death. This medical practice does not have to agree to your request, but if we do, we will abide by our agreement until either of us terminates the agreement.

I hereby request special privacy protection for _____.

This is a complete list of all restrictions requested. All previous restriction requests are obsolete.

☐ I do not want my health information be disclosed to any of the following (attach additional pages if needed):

Name: _____ Address: _____

Name: _____ Address: _____

☐ I do not want my health information used or disclosed for any of the following purposes (attach additional pages if needed):

_____

_____

Print Name: _____ Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ other (specify)

NOTE: By law, this restriction will not apply with respect to information necessary to provide emergency treatment, for uses or disclosures required by law, or for certain public health activities, judicial and administrative proceedings, law enforcement purposes, coroner investigations, organ or tissue donations, research activities, specialized government functions or workers' compensation activities.