Robert W. Baritz, D.C., P.C.
HIPAA Authorizations & Acknowledgement

Appointment Reminders & Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. Contact may take the form of an e-newsletter. Contact may also be by postcard offering a free preventative check-up or a free office visit. By signing this form, you are giving us authorization to contact you with these reminders and information.

- You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, 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.
- Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be subject to federal privacy rules.
- You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use 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 related health information at any time. (§164.524)
- This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.
- Patient e-mail address: _____
- I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____	_____	_____	_____
Patient Signature (or rep's)	Date	Patient Name, Printed	Provider Representative

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 disclosures 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 Dr. Baritz's *Notice of Privacy Practices for Protected Health Information*:

_____	_____	_____	_____
Patient Signature (or rep's)	Date	Patient Name, Printed	Provider Representative

_____	_____	
Patient Representative Printed	Description or patient's representative's authority to act for the patient	V.4.9.03