Authorization for Disclosure of Confidential Information

Patient Name____

DOB____________________ Social Security_____________________________

To Whom It May Concern:

I hereby authorize the office of Dr. Jennifer Ridley (LiveWell Chiropractic) to release to:

____ Spouse ____ Other family member ____ Leave message on voicemail or recorder

____ Other ____

On any medical information on the above named patient for any results on medical testing or procedures including any or all medications.

I understand that my records are protected under the federal confidentiality regulations and cannot be disclosed without my written authorization. I understand that I may revoke this authorization at any time except to the extent that has been taken in reliance on it (e.g., probation, parole, etc.) and this authorization will expire upon written authorization by me. The purpose for which this information is being released is for the medical care of the patient.

Signed____ Date_______________

Witness____ Date_______________

749 Lonesome Dove Trl.
Hurst, TX 76054

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and redirect my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____

Relationship to patient (if signing for a minor) ____

Signature____

Date____

Office use only

I attempted to obtain the patient's signature in acknowledgement of this notice of Privacy practices Acknowledgement, but was unable to do so as documented below:

Date:_______________

Initials:______________

Reason:____