Fasulo Chiropractic

Embrace Life Holistically

Patient's Name (Print):_____ Date of Birth: _____/_____/_____

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient Information except as stated In the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes Fasulo Chiropractic to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my home telephone:
□ Yes □ No

Leave a voice mail recording including my Personal Health Information on my cell phone:
□ Yes □ No

Leave a voice mail recording including my Personal Health Information on my business phone:
□ Yes □ No

Leave a voicemail regarding only appointment confirmations on my home, cell phone or business phone number:
□ Yes □ No

Use of electronic communication systems (I.e., fax, electronic messaging) to transmit prescription, treatment, disorder related Information, lab or other results:
□ Yes □ No

Use of email to transmit treatment or disorder related Information which may include a diagnosis, lab or other result sent to me, even if the email is not encrypted (not protected over the internet.)
□ Yes □ No

Permit the individual stated below (Personal Representative) to receive test results:
□ Yes □ No

Speak to a family member of my choosing (Personal Representative as designated below) regarding my Personal Health Information;
□ Yes □ No

Name of Designated Personal Representative (PRINT):_____

Relationship to Designated Personal Representative: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

On this date_____, I received, and reviewed Fasulo's Notice of Privacy Practices, which describes how my medical Information may be used and disclosed and explains how I can get access to this Information. I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

The authorizations made above will remain effective until such time as I notify Fasulo Chiropractic in writing, by certified mail, of requested changes.

_____ _____
Patient or Parent/Guardian Signature Today's Date

_____ _____
Patient Social Security Number Email Address

_____ _____
Patient Home Telephone Number Other Contact Number