PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

DATE: _____ **DOB:**_____

I acknowledge receipt of a copy of the current effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request MEDICAL RECORDS be sent to other attending doctor/facilities in the future.

_____ _____

Please **print** your name Please **sign** your name

Email Address: _____for Patient Portal Access

Please list any people who can have access to your health information: (This includes step parents, grandparents, and any caretakers who can have access to this patient's records):

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

I authorize contact from this office to **confirm my appointments, treatment & billing information via:**

□ Cell Phone □ Home Phone □ Work Phone

I authorize **information about my health** to be conveyed via:

□ Cell Phone □ Home Phone □ Work Phone

□ Patient Portal (via email) □ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. We, under current HIPAA Omnibus Rule provide you this information with your knowledge and consent.

Birmingham Integrative Health
Cancellation and No Show Fee

I_____ acknowledge that there is a **$50 fee** for missing my appointment or not cancelling or rescheduling **24 HOURS** before my appointment. (Business days, not weekends.)

Name: _____

Signature: _____

Date of Birth: _____

Today's Date: _____

For HIPAA privacy complaints, please contact Office Manager Malcolm Lehr at 205-655-2110.