**Acknowledgment Privacy Policy Offered**

My health information may be created or reviewed by Center for Integrative Medicine and may be in the form of written or electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, prescriptions and similar types of related health information.

I understand that I have the right to receive and review a written description of how Center for Integrative Medicine will handle my health information. This written description is known as a Notice of Privacy Practices. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Center for Integrative Medicine and my right regarding my health information. I may obtain a copy of the Notice of Privacy Practices at the reception.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of Center for Integrative Medicine’s Notice of Privacy Practices in effect will be posted in the waiting/reception.

**Patient Confidential Communication**

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following. I give permission to Center for Integrative Medicine to leave messages regarding:

* Appointments
* Billing information
* Limited medical information, such as: normal results (Abnormal results and sensitive information will never be left on voice message), generic recommendations, medication information or referral status or updates on any of the following phone numbers listed on patient information form:
* Home
* Mobile
* Work

And/Or with the following person(s):

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_

This release will be revoked by written permission only. I understand that I must send a written request to Center for Integrative Medicine in order to revoke this request. When translation services are utilized, you give express consent that it may be done using a wireless mobile device.

**Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.** If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

Patient Name (Please Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

Signature (Patient/Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_