

**HIPAA Acknowledgement, Appointment Reminders, and Authorized Party(ies)**

I acknowledge that I have been provided access to the “Notice of Privacy Practices” (“**Notice**”) of Tallgrass Acupuncture and Wellness, LLC (“**Tallgrass**”). I understand that I have the right to review the Notice prior to signing this document.

I understand that Tallgrass staff members may need to contact me with appointment reminders or information related to my treatments. I understand and agree that this contact may be made via telephone (voice call or text message) or email. If this contact is to be made by voice call, and I am not at home or do not answer my phone, I understand and agree that a message will be left on my answering machine or with anyone who answers the phone. By signing this form, I am giving Tallgrass authorization to contact me by telephone or email.

I hereby authorize Tallgrass to use or disclosure of my individual identifiable health information to the individuals or entities identified below (the “**Authorized Party(ies)**”). I understand this authorization is voluntary and OPTIONAL. I understand if any Authorized Party is not a HIPAA-covered entity (i.e. a health plan or health care provider), the released information may not be protected from further disclosure by federal privacy regulations.

My Authorized Parties, if any, are (print name and relationship):

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| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ |

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Printed Name |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date |