INTEGRATIVE HEALTH SPECIALISTS OF INDIANA

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF INTEGRATIVE HEALTH SPECIALISTS OF INDIANA

Patient's Name:			
	Last	First	Middle Initial
Date of Birth:			

I hereby acknowledge that I have received/reviewed the Notice of Privacy Practices of INTEGRATIVE HEALTH SPECIALISTS dated April 14, 2003.

_______________________________________ _______________

Signature of Patient (or Healthcare Representative) Date

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Printed Name of Healthcare Representative

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Relationship to Patient

May our office leave medical information on your voicemail?

☐ **Home phone** ☐ **Cell phone** ☐ **No**

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THOSE INVOLVED IN THE PATIENT'S CARE AND FOR NOTIFICATION PURPOSES

I, ____________________________, request that Integrative Health Specialists disclose to the following family members or friends my protected health information that is directly relevant to such person's involvement with my care or payment related to my care. Integrative Health Specialists may also use or disclose this information as necessary to notify the following individuals of my general condition, location or death.

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_______________________________________ _______________

Signature of Patient (or Healthcare Representative) Date

If patient is unable to sign, but circumstances are such that it can be reasonably inferred that the patient intends to consent to such disclosure, so note by checking and initialing here:

☐ ______________________________

A copy of this written acknowledgment shall be placed in the medical record.