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:______________________
Month / Date / Year

I hereby acknowledge that I have received the Notice of Privacy Practices of INTEGRATIVE HEALTH SPECIALISTS OF INDIANA dated April 14, 2003

____ __________________________
Signature of Patient (or Healthcare Representative) Date

____ ________________________
Printed Name of Patient (or Healthcare Representative) Relationship to Patient's

May our office leave medical information on your:
Answering machine at home: YES NO **Cell phone voicemail: YES NO**
Laboratory & test results can be sent to you by email: YES NO
Email Address____
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<u>PERMISSION</u> TO DISCLOSE PROTECTED HEALTH INFORMATION TO THOSE INVOLVED INT THE PATIENT'S CARE AND FOR NOTIFICATION PURPOSES

I, (patient name) _____________________________, request that Integrative Health Specialists disclose to the following family members, friends or other health care providers 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.

****Please list family, friend or health care providers Name(s) and Relationship to you:**
(use back side of form if necessary) **<u>OR</u>** put **N/A** if you do not want information shared with anyone

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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 consent to such disclosure,
so note by checking here ____ and Initialing here______________

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