DHHS, Office of Civil Rights
200 Independence Ave, S.W., Room 509F HHH Building
Washington, DC 20201

HIPPA NOTICE

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By the way of my signature, I provide Lifetime Wellness with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient Information Authorization

Name: _____ Date:_____

Home #: _____ Cell: _____Work: _____

Email address: _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

⑧ OK to leave me a message with detailed information   ⑧ cell phone   ⑧ home phone   ⑧ work phone   ⑧ email
⑧ OK to leave message with call back number only   ⑧ cell phone   ⑧ home phone   ⑧ work phone   ⑧ email
⑧ Primary mode of contact   ⑧ cell phone   ⑧ home phone   ⑧ work phone   ⑧ email

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Signature _____ Date of Birth: _____

Patient Name(print) _____