## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:________________________________________________

Address:________________________________ __________ ____ __________

Date of Birth:______________________________Date of Request:____________________

**As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize Dr Rebecca Pearson, LLC dba Health Back Center, and any of its employees to use or disclose my Patient Health Information to the following persons(s), entity(s), business associates of this office (insurance carrier(s) or other listed entity (s):

Any insurance company or other entity I have requested claims be filed to as a courtesy and on my behalf and:

______________________________________________________________________

Patient Health Information authorized to be disclosed:

Personal, Financial & Medical Records
All information collected in patient record necessary to verify, process and submit insurance claims

For the specific purpose of (describe in detail):

Care of patient, management of records, billing and insurance processing

**Effective dates** for this authorization: From: ___/___/___through ___/___/___.
This authorization will be continuous unless expiration date indicated above. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information. However, I do understand that refusal to sign this document may prevent this office from assisting with the filing of my insurance claims.

______________________________________________ ______________________
*Signature of Patient or Patient's Authorized Representative* *Date*

______________________________________________ ______________________
*Authorized signature of Facility* *Date*

HIPPA CONTACT FORM
REQUEST FOR CONFIDENTIAL COMMUNICATION BY
ALTERNATIVE MEANS OR ALTERNATE LOCATION

I, ________________________________, Date of Birth_____________authorize/request an alternative means of communication of my health information (e.g., regular mail, telephone, facsimile) or communication of my health information to an alternate location.

I understand that request for communication by alternative means or to an alternate location is applicable only to information held by Health Back Center and disclosure by alternative means may not be protected and could endanger me. I understand that request for alternative means of communication may be intercepted by others and Health Back Center is not responsible if such intercepts occur.

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Please indicate in detail your authorized alternative means or alternate location for receiving communications from Health Back Center.

☐ Email Reminders: ________________________________________________

☐ Phone Call Reminders: ____________________________________________

☐ Permission to leave message on voicemail/recorder: ☐ Yes ☐ No

☐ Alternate Mailing Address:

__________________________________________ ________ __________

☐ Use mailing address provided on initial paperwork or by written update.

☐ Alternate Phone Number

☐ Alternate Means of Contact (Please specify):

This request applies to the following information: ☐ Today's Date of service only
☐ From:__________ ☐ To:___________
☐ From:__________ Until Further Notice

| SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE<br>(If Personal Representative, state relationship to patient) | DATE |
| --- | --- |
| SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark) | DATE |

FOR HBC USE ONLY

☐ Request Approved ☐ Denied
If denied, reason (check one):
☐ Request is not reasonable to accommodate ☐ Alternate address or contact not provided
☐ Failure to provide information on how payment will be made (if applicable)
☐ Other (please explain):______________________________________________

# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.


**SUMMARY:**
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.


As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

| Effective Date of this Notice: | October 22, 2013 |
|---|---|
| Contact Person: | Dr. Rebecca Pearson |
| Phone Number: | 417-337-7100 |

### Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way."

_______________________________________

*Patient or Representative Name (please print)*

_______________________________________ ____________

*Patient or Representative Signature* *Date*

☐ Patient refused to sign ☐ Patient was unable to sign because

_______________________________