Madeleine Morrison N.D.

HIPAA Communication Form

Patient Name:_____ Date of Birth:_____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

This consent form, when signed, gives us permission to release necessary medical information to your medical insurance provider to process your claim, as well as to the pathologist, lab, or other doctor(s) who may be consulted in your diagnosis and treatment. Each of the above will also treat your information with the strictest confidence. This signed consent form gives us authorization to provide your information to a specific person other than yourself. Your medical information is otherwise confidential.

Do we have your permission to:

Leave a message on your answering machine at home or cell phone? Yes___ No___

Leave a message at your place of employment? Yes___ No___

Leave a text message? Yes ___ No ___

Discuss your case with a member of the Spirit Path Clinic? Yes _____ No ____

If yes, whom _____

Discuss your medical condition with any member of your household? Yes___ No___

If yes, whom:_____

Relationship:_____

Email Release

I want to communicate by email with patients on matters of my medical treatment. I understand that and confidential health information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice or any of its members liable for any loss of confidentiality associated with information transmitted via email.

I also understand that is not the policy of the practice to encrypt any confidential health information; given that this information is not encrypted I understand that it is not secure. I acknowledge this is a risk and I will not hold the practice or any of its members liable for any loss of confidentiality associated with such transmissions.

Initials: _____

By signing below, you understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Madeleine Morrison N.D. ha a Notice of Privacy Practices and you have the opportunity to review this Notice.
- Madeleine Morrison N.D. reserves the right to change the Notice of Privacy Practices. If we change our Notice, you may obtain a revised copy by contacting our office.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Madeleine Morrison N.D. may alter provision of services upon the execution of this Consent.
- In addition, you acknowledge receipt of Madeleine Morrison N.D.'s Notice of Privacy Practices provided to you today.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Description of Personal Representative's Authority

_____ _____

Signature of Witness Date