STRUCTURAL REGENESIS NEURAL ORTHOPEDICS LLC · NAPRAPATHIC MEDICINE

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HIPAA Privacy Authorization Form

I, _____ have received a copy of the Notice of Privacy Practices from the office of STRUCTURAL REGENESIS NEURAL ORTHOPEDICS LLC ·(SRNO).

1. I hereby authorize **SRNO** to use and/or disclose the protected health information described below to _____. (Name of Individual)
2. Authorization for Release of information covering the period of health care of
   - a. ☐ All past, present, and future records
   - b. ☐ Records dated _____ to _____
   - c. ☐ I hereby authorize the release of my complete health records (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. This authorization shall be in force and effect until I revoke the authorization.
5. I understand that I have the right to revoke this authorization, in writing, at any time, I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I authorize **SRNO** to leave appointment reminders or discuss treatment information through the following means:

- a. ☐ I do _____ ☐ I do not _____ authorize communication to my **home phone #**
- b. ☐ I do _____ ☐ I do not _____ authorize communication to my **work phone #**
- c. ☐ I do _____ ☐ I do not _____ authorize communication to my **cell phone #**
- d. I Prefer to be reached at the following number (_____) _____
- e. I prefer reninders be sent via this EMAIL - _____

Signature of Patient: _____ Date: _____

Print Name: _____ Relationship to Patient: _____