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 Becky Post Living on Purpose 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 (CIRCLE ALL THAT APPLY):
OK to leave me a message with detailed information:
cell phone yes or no
home phone yes or no
work phone yes or no
email yes or no
OK to leave message with call back number only:
cell phone yes or no
home phone yes or no
work phone yes or no
email yes or no
Primary mode of contact:
cell phone yes or no
home phone yes or no
work phone yes or no
email yes or no

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) _____