Affordable Care Act
Electronic Health Records Access

In compliance with requirements for the Affordable Care Act EHR program

Patient Name: (Last, First) _____ , _____ DOB _____

The Act provides individuals with a right to obtain their Private Health Information (PHI) in an electronic format (ePHI). An individual can also designate that a third party be the recipient of their ePHI. ***Pt initial _____***

I understand that can get a copy of my medical records any time I request them in the future therefore I choose to decline receipt of my daily summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)* ***Pt initial _____***

The Act requires us to report on your race and ethnicity. (Please Check One) Race: □ American Indian or Alaskan Native □ Asian □ Black or African American □ White or Caucasian □ Hawaiian or Pacific Islander □ Other or □ Decline to Answer

The Act requires us to report specific personal information such as your height and weight, your diagnosis, if you smoke and if you drink. The Act requires us to report additional information about you over time.

Medical Information Release Form (HIPAA Release Form)

Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information to the authorized person(s) named below:

My Personal Health Information may be released to the following authorized person(s):

(Check all that Apply & Write their Name on the Form)

[ ] Spouse or Significant Other _____

[ ] Child(ren)_____

[ ] Other_____

[ ] My Information [ ] is to be [ ] is NOT to be released to my employer even with a signed HIPAA release form.

[ ] My Information is not to be released to anyone.

Authorized Person(s) named above may: (Please chose one)

[ ] Authorized Person(s) may discuss my PHI in person, writing or via phone.

[ ] Authorized Person(s) may discuss and receive copies of my PHI.

[ ] Authorized Person(s) may discuss, receive copies of, and make changes to my PHI (e.g. address changes, etc.).

[ ] Authorized Person(s) may do anything I am permitted to do.

HIPAA Communication Preferences

For Phone Calls, Messages, Please call: [Check all that apply]
[ ] my home phone [ ] my work phone [ ] my cell phone

If unable to reach me on the phone: [Please check one]
[ ] you may leave a detailed message (by voice).
[ ] please leave a message only asking me to return your call.
[ ] _____

For Text Messages: Cell phone carrier (Circle One) **Verizon AT&T T-Mobile Other** _____.
I understand that I will receive text messages from Millar Functional Medicine about my appointments, my health, my health conditions and problems, and general health information. [Please check one]
[ ] you may leave a detailed message (by text).
[ ] please leave a message asking me to return your call.
[ ] _____

For E-mail: I understand that I will receive e-mails from both 1) my Doctor and 2) Millar Functional Medicine about my appointments, my health, my health conditions and problems, and general health information. [Please check one]
I may change my e-mail preferences at any time by clicking the link on the e-mail sent to me.
[ ] you may send me detailed e-mails.
[ ] please leave an e-mail message asking me to call the clinic.
[ ] _____

HIPAA Rules

- **You are not allowed to take pictures or videos of other patients in our clinic.**
- **You are not allowed to connect your phone, USB or other memory device or any other personal device to any Millar computer, tablet, or data port in our clinic.**
- **<u>You are allowed to connect to the Free Guest Wi-Fi provided</u>. Please note that the Free Guest Wi-Fi is not secure. The password is millar123.**

This form will be valid for (7) seven years from the date of your last appointment either in person, by telemedicine or group. I want this to cover all services provided. I may revoke this authorization at any time by sending written notice, however, revocation will not affect any action previously taken in reliance on this authorization prior to my revocation. My signature below constitutes understanding and acceptance of this entire document and all provisions contained on both pages 1 and 2 herein.

Patient Signature: _____ **Date:**_____