



## Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

### OPTIONAL:

\_\_\_\_\_ I wish to file a "Request for Alternative Communications" of my protected health information. (*such as "please allow [name], my spouse, to see my records at any time"*) Write your request below.

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*I understand this office is not required to honor any requested changes to the "Notice of Privacy Practices."*

### **I have read the full Privacy Notice and understand my rights contained in this notice.**

By way of my signature, I provide this practice with my authorizations and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice. (Upon request, I will be provided a copy of the full HIPAA Privacy Statement).

**Signature** \_\_\_\_\_ **date** \_\_\_\_\_

**Print name** \_\_\_\_\_

**OFFICE USE:** *Authorized Facility Signature* \_\_\_\_\_ This notice is effective as of July 1, 2009.

## Assignment of Benefits

I authorize my attorney and/or an insurance company to make payment directly to Gelardi Chiropractic for services rendered.

In so authorizing, I realize that I am still fully responsible for payment.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## Authorization to Release Information

I authorize Gelardi Chiropractic to release information to the appropriate entities (insurance companies and my attorney) for the purpose of receiving assigned benefits.

Signed \_\_\_\_\_ Date \_\_\_\_\_