Acknowledgment of Receipt of Notice of Privacy Practices
(Consent for Treatment Form)

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, Travis Taira, D.C. Inc. is required under Federal Law to obtain your consent. Please review this consent. If you agree to its terms, please sign and date this consent below.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices prior to signing this consent.

By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment or healthcare operations.

You have the right to request restrictions how your protected health information is used or disclosed to carry out treatment, payment or healthcare operations. However, we are not required to agree with such restrictions. If we agree to a restriction that you request, such restriction will be binding.

Your have the right to revoke this consent in writing. Except to the extent that we have taken action in reliance on your consent.

I, _____ (PATIENT NAME), hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between myself and Travis Taira, D.C. Inc. No other individuals/organizations have permission to obtain my confidential information under this consent.

This consent form will be kept in your patient file for a period of six (6) years.

_____ _____

Signature of Patient/Parent or Guardian Date

_____

Print Name

Patient Disclosure Authorization Form
(HIPPA – Patient Privacy)

Patient Name_____ Date _____

I authorize disclosure of my protected health information only in the specific manner, for named reason, and to the specific individual(s) and relation listed below.

I authorize disclosure and/or discussion regarding existing appointment confirmations, changes, or cancellations.

_____

I authorize confirmation of my chiropractic appointments via phone:

_____ Resident phone _____ Business phone _____ Cellular phone _____ leave message/voice mail

I authorize disclosure and/or discussions of treatment for future and completed chiropractic treatment to:

_____

I authorize disclosure of charges and payments regarding my account to:

_____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature _____ Date _____