REJUVENATE

Authorization of Use and Disclosure of Protected Health Information

Appointment Reminders

The practice may use your information to remind you about upcoming appointments. Typically, a brief, non-specific message may be left on your answering machine or voicemail.

If you have an answering machine or voicemail, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at **REJUVENATE!**.

_____ YES _____ NO

If "NO", how else may we contact you regarding this information?

Please list any other restrictions regarding messages or reminders about your healthcare:

Use and Disclosure of Information

_____ I authorize the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at **REJUVENATE!**

___________________________________ ___________________________________

Name / Relationship **Name / Relationship**

_____ I do **not** authorize my information to be disclosed to any other parties except to me as the patient.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **REJUVENATE!**. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-Disclosure

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

____

Name of Patient (PRINT)

___________________________________ ____________________

Signature of Patient or Patient Representative **Date**

Notice of Privacy Practices Patient Acknowledgement

Patient Name: ________________________________

Date of Birth: ________________________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ___________________________________ Date: ____

Relationship to patient (if signed by a personal representative of patient):

____