ADVANCED WOMEN'S WELLNESS, PLLC

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ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS FORM

BY SIGNING BELOW:

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy. I acknowledge that I have received the *Notice of Privacy Practices* (HIPAA) and I consent to the use and disclosure of my health information as described.

Please let us know how you authorize the release of personal health information:

- I am the only one who should receive information regarding my health information (example: test results, billing, etc.). **Okay to leave a detailed message on my primary phone number?**

  ☐ **Yes** ☐ **No.** **If yes, preferred phone number is**: _____

- I, _____, authorize the release of my health information including diagnosis, examinations rendered to me and claims/billing information. This information may be released to:

  - Spouse _____ Phone number: _____
  - Child(ren)_____ Phone number: _____
  - Other_____ Relationship:_____

    Phone number: _____

  I request the following restrictions on the use/disclosure of my health information:

  _____

***Information and care of patients 18 and older will not be discussed with anyone except for the patient herself, unless the patient signs a new form. ***

Patient Name: _____
(Print Name)

Patient Date of Birth: _____

Patient/Legal Representative Signature: _____**Date**_____

Relationship to Patient (if applicable): _____

***This authorization will remain in effect until revoked by patient or legal representative**