Bliss
Wellness Center

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Bliss Integrative Medicine Center, LLC (BIMC) "Notice of Privacy Practices". I understand that I have the right to review BIMC's "Notice of Privacy Practices" prior to signing this document.

I understand that BIMC staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not able to answer the call, a message will be left in my voicemail or with anyone who answers the phone.

By signing this form, I am giving BIMC authorization to contact me. I acknowledge that all information discussed during the assessment and treatment at a BIMC clinic will be held confidential except in the instance where my safety or the safety of others may be at risk or where communicating with my other healthcare providers allows for the best of collaborative and integrative care for me.

_____
Patient Name (print)

_____ _____
Patient Signature / Date

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize the Bliss Integrative Medicine Center, LLC the use or disclosure of my individual identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____

_____

_____

_____
Patient's Signature / Date