LAST NAME FIRST NAME M.I. DATE OF BIRTH

CCATR

HIPAA Privacy Authorization Form

I, _____ have received a copy of the Central Coast Alternative Therapeutics and Rejuvenation's HIPAA authorization form. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care preparations such as quality assessments and accreditation.

Patient:_____

Signature:_____

Date:_____

OFFICE USE ONLY
We attempted to obtain written HIPAA Privacy Authorization Form, but consent could not be obtained because: ● Individual refused to sign ● Communication barriers prohibited obtaining the acknowledgement ● An emergency situation prohibited us from obtaining acknowledgement ● Other (please specify)_____ _____ Staff Signature_____