# Elevate Your Wellness Center

## HIPAA Privacy Authorization Form

I, _____ have received a copy of the Elevate Your Wellness Center'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:<br>● Individual refused to sign<br>● Communication barriers prohibited obtaining the acknowledgement<br>● An emergency situation prohibited us from obtaining acknowledgement<br>● Other (please specify)_____<br>_____<br>Staff Signature_____ |