

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:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prohibited us from obtaining acknowledgement
- Other (please specify) _____

Staff Signature _____