Kovach Chiropractic and Wellness Center
959 Annapolis Road
Gambrills MD 21054

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Kovach Chiropractic and Wellness Center *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____
_____
(Print) Date

Signature of Personal Representative:
_____

Relationship to Patient: _____ Driver's License Number: _____State____

We have made the following attempt to obtain the patient's signature acknowledging receipt of the *Notice of Privacy Practices*:

Attempt 1: _____Date _____ Staff: _____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Office Use Only

Kovach Chiropractic and Wellness Center
959 Annapolis Road
Gambrills MD 21054

PHI Use and Disclosure Authorization

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone, text or email

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Kovach Chiropractic disclosure of my individually identifiable health information to the individuals listed:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

This authorization is effective through (check one):

- ❑ ____ /____ /____

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Kovach Chiropractic in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Kovach's Chiropractic until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____

Signature of *Personal Representative* if applicable **Date**

***Relationship* to Patient: _____Driver's License Number: _____State____**