Bratcher Injury & Wellness Center, P.A.

HIPAA Alternative Access Form

Patient Name_____ Date of Birth_____

Release of Information

I authorize the release of confidential communication of protected health information to be given to the following person/persons.

Spouse_____ Ph# _____

Child_____ Ph# _____

Child_____ Ph#_____

Other_____ Ph#_____

Relationship to patient_____

*The **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: My Home _____ My Cell_____

My Work_____

***If Unable to Reach Me You May:**

Leave a detailed message: Yes or No

Leave a message asking me to return your call: Yes or No

Do not leave a message other: _____

Signature_____ **Date:** _____

Acknowledgement of Review of Notice of Privacy Practices

I am aware of this office's **Notice of Privacy Practices,** which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient/Representative: _____

Date of Birth: _____ **Date:** _____

Printed Name: _____

Description of Representative's Authority: _____

_____

Office Employee Signature:: _____

***If refusal to sign please state reason and document patient received a copy of the policy.**

_____

_____

_____

_____

_____

_____

_____

Signature of Employee_____