

Family Chiropractic Services

Dr. Lisa Vizzacco-Smith

PATIENT RECORD OF DISCLOSURES

The HIPPA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Home/Cell Telephone: _____

Work Telephone: _____

OK to leave detailed message

OK to mail home address

OK to leave detailed message

Leave message with call-back number only

Leave message with call-back # only

Other persons you ALLOW us to disclose your health information:

Name	Phone	Relationship
		Attorney
		Insurance Co.
		Relationship
		Relationship
		Relationship

IF YOU REQUEST ANY RESTRICTIONS PLEASE LIST BELOW:

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I request that payment of medical benefits be made to the above-named doctor on my behalf, for any services provided to me. I authorize the holder of medical and other information about me to release to Medicare and any insurance company information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges not paid by my insurance company.

I have received the Notice of Privacy Practices and/or I have been provided an opportunity to review it.

Patient's Name (Printed): _____ Date: _____

Patient's Signature

Birthdate:

OFFICE USE ONLY

Date	To Whom info Disclosed	Authorized	Desc. Of Disclosed Info.	Disclosed by	How disclosed