BRANNICK CLINIC
of Natural Medicine
WHOLE HEALTH PRIMARY CARE & WELLNESS

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your physician and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us the authorization to contact you with these reminders and information and to leave a massage on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which you health care information is released or you may revoke your authorization to us at any time: however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information, and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health information at any time.

This notice is effective, as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient Name Printed Date

X_____ X_____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Print Personal Representative Signature

Description of personal representative's authority to act for the patient.

BRANNICK CLINIC
of Natural Medicine
WHOLE HEALTH PRIMARY CARE & WELLNESS

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to review to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by email.

Your right to limit uses or disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies, or organization. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke authorization
You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information)

Print Patient Name _____

Patient Signature X_____ Date_____

Authorized Provider Representative Signature X_____