THE CENTER FOR TOTAL BACK CARE

Authorization to Release Information

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) I have certain rights to privacy regarding my protected health information. I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my healthcare information. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I understand that you are required to have authorization to leave a message at my home or on my answering machine, regarding appointments, labs, imaging, and billing and insurance information.

____ It is ok to leave a message on my answering machine with information regarding my health care.

____ It is **NOT** ok to leave any messages on my answering machine.

Patient Signature _____ Date _____

I understand that my signing this consent form, I am giving The Center For Total Back Care permission to disclose all medical treatment and billing information, unless otherwise indicated, to the following person or persons.

Authorized Person _____ Relationship to Patient _____

Authorized Person _____ Relationship to Patient _____

Authorized Person _____ Relationship to Patient _____

Authorized Person _____ Relationship to Patient _____

Acknowledgment of Privacy Practices

I have read a copy, and understand the Privacy Practices of The Center For Total Back Care.

_____ _____

Patient Parent or Legally Authorized Individual

_____ _____

Date Relationship to Patient