

# TEXAS ACUPUNCTURE CLINIC

## HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Texas Acupuncture Clinic (TAC) "Notice of Privacy Practices". I understand that I have the right to review TAC's "Notice of Privacy Practices" prior to signing this document.

I understand that TAC staff members may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

Information stripped of any personal identifiers may also be used for research and educational purposes by individual practitioners or TAC. By signing this form, I am giving Texas Acupuncture Clinic authorization to contact me with these reminders and to utilize my information for research and educational purposes.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
TAC Privacy Rep/Date

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**Authorization for Release of Health Information (Optional)**

I, \_\_\_\_\_, hereby authorize the Texas Acupuncture Clinic the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

*Persons/Organizations authorized to receive information: (please print)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date