

HIPAA Acknowledgment and Appointment Reminders Form

I acknowledge that Metta Oriental Medicine, P.C. has provided me with a "Notice of Privacy Practices". I understand I have a right to review Metta Oriental Medicine's "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" Center is also provided on request.

Members of the staff may need to contact you with appointment reminders or information related to your treatment. If this contact is made by phone, and you are not home, a message will be left on your answering machine or with whoever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information

Patient Name (printed) *Date*

Patient Signature *Date*

Privacy Officer: Jessie Lin *Date*

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Metta Oriental Medicine, P.C. to use or disclose of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive my information is not a health insurance plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

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

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Patient Signature

Date

Metta Oriental Medicine, P.C.
2653 Tarna Drive,
Dallas, TX 75229
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