Jiv Daya Whole Health

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the Jiv Daya Whole Health (JDWH) "Notice of Privacy Practices". I understand that I have the right to review JDWH's "Notice of Privacy Practices" prior to signing this document. I understand that JDWH's 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/do not answer, a message will be left on my voicemail or answering machine, or with anyone who may answer the phone. I also understand that my clinical information may be used for educational and/or research purposes by JDWH or individuals authorized by JDWH. All information that can identify me personally will be removed.

By signing this form, I am giving JDWH authorization to contact me and I am giving my informed consent to utilize my information for research and educational purposes. I acknowledge that all information discussed during the assessment and treatment at JDWH will be held confidential, except in the instance where my safety or the safety of others may be at risk.

______________________________ ______________________________

Patient Name (print) Date

______________________________ ______________________________

Patient Signature Jiv Daya Whole Health Rep/Date

Authorization for Release of Health Information (Optional)

I, ______________________________, hereby authorize Jiv Daya Whole Health 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 Signature **Date**