HIPAA Privacy Authorization Form

Cancellation/No Show Policy

\*\*Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.

Parts 160 and 164)\*\*

\*\*1. Authorization\*\*

I authorize \_\_\_\_\_Equilibrium Balancing Health LLC\_\_\_\_ (healthcare provider) to use

and disclose the protected health information described below to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (individual seeking the information).

\*\*2. Effective Period\*\*

This authorization for release of information covers the period of healthcare

from:

1. □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\*\*OR\*\*

b.  all past, present, and future periods.

\*\*3. Extent of Authorization\*\*

a. □ I authorize the release of my complete health record (including records

relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of

alcohol or drug abuse).

\*\*OR\*\*

b. □ I authorize the release of my complete health record with the exception

of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. This medical information may be used by the person I authorize to receive

this information for medical treatment or consultation, billing or claims payment, or

other purposes as I may direct.

5. This authorization shall be in force and effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date

or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing,

at any time. I understand that a revocation is not effective to the extent that any

person or entity has already acted in reliance on my authorization or if my

authorization was obtained as a condition of obtaining insurance coverage and the

insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for

benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this

authorization may be disclosed by the recipient and may no longer be protected by

federal or state law.

Cancellation/No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $50.00 cancellation fee.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good provider/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department 877.270.7191

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of patient or personal representative

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed name of patient or personal representative and his or her relationship to patient

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date