ORIENTAL MEDICINE ASSOCIATES

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that the Oriental Medicine Associates (OMA) "Notice of Privacy Practices" has been provided to me. I understand I have a right to review OMA's "Notice of Privacy Practices" prior to signing this document. "The Notice of Privacy Practices" for OMA is also provided on request at the front desk of this practice or on OMA's website at www.orientalmedicineassociates.com.

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.

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Patient Name (Printed) Date

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Patient Signature Date

Name of Privacy Officer: Kathy Kerr

Authorization for Release of Health Information (Optional)

I,________________________________, hereby authorize Oriental Medicine Associates the use or disclosure 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 plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

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

______________________________ ______________________________

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Patient Signature **Date**