HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

Clients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications and/or information at that email or text address from the Practice.

_____ (printed client name) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders, feedback and health information unless I request a change in writing (see revocation section below).

The ***cell phone number*** that I authorize to receive text messages for appointment reminders, feedback, and general health reminders and/or information

is_____.

The ***email*** that I authorize to receive email messages for appointment reminders and general health reminders, feedback and/or information

is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Signed this _____day of _____ 20_____.

Print Name _____

Signature _____

Relationship to Client, if client is a minor:_____

Received by Representative of the Practice:_____

Practice Name:

Coronado Island Wellness Center
DBA Coronado Island Massage
1123 Tenth Street
Coronado, CA 92118
(619) 865-1053

Revocation

I hereby revoke my request for future communications via email and/or text. _____

I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages. _____

I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Signed this _____day of _____ 20_____.

Print Name _____

Signature _____

Relationship to Client, if client is a minor:_____