Aloha Sophia Wellness, LLC
4506 Lehua Street, Kapaa, HI 96746
Phone: 808-823-0418
www.AlohaSophia.com
info@alohasophia.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & AUTHORIZATION

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Aloha Sophia Wellness' *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____
Patient Name (print) Patient's Date of Birth

Address: _____

Home phone _____ Mobile Phone _____

Work Phone _____ Email Address _____

_____ _____
Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____
(Print) Date

Signature of Personal Representative: _____

Relationship to Patient: _____ Drivers License Number: _____ State_____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the *Notice of Privacy Practices*:

Attempt 1: _____ Date _____ Staff: _____

Attempt 2: _____ Date _____ Staff: _____

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PHI USE AND DISCLOSURE AUTHORIZATION

If you wish to have your medical or billing information released to family members you must fill out the information and sign below.

I hereby authorize Aloha Sophia Wellness' disclosure of my individually identifiable health information to the individuals listed:

1. Name _____ Relationship to Patient _____

Authorization to:

- ☐ Disclose treatment plans and test results _____
- ☐ Billing information including statement balances
- ☐ Past and future Appointments
- ☐ Receive phone messages and/or email regarding appointments or test results
- ☐ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ☐ Disclose treatment plans and test results _____
- ☐ Billing information including statement balances
- ☐ Past and Future Appointments
- ☐ Receive Phone Messages or email regarding appointments or test results
- ☐ Other _____

We have permission to (please check all that apply):

- ☐ Leave messages on home phone or with household members
- ☐ Leave messages on work phone
- ☐ Leave messages on cell phone
- ☐ Confirm appointments or class reminders by ____ phone ____ text ____ unencrypted email
- ☐ Contact you regarding need to update billing information by ____ phone ____ text ____ unencrypted email
- ☐ Send an invoice by ____ text ____ unencrypted email
- ☐ Send a purchase receipt, upon request, by unencrypted email
- ☐ Send emails with access to newsletters, educational information

This authorization is effective through (check one):

- ☐ _____ /_____ /_____
- ☐ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Aloha Sophia Wellness in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Aloha Sophia Wellness until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative Date

Relationship to Patient: _____ Drivers License Number: _____ State _____