HIPAA Disclosure Questionnaire

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (*including treatment, payment and health care operation).*

Please list the family members or significant others, if any, whom we may inform about your Medical condition **ONLY IN AN EMERGENCY**:

Please print the telephone number(s) and email address where you want to receive calls about your appointments, lab, and x-ray results, or other information, postal consent if applicable

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Check appropriate boxes:

- ▫ Okay to leave message with detailed information
- ▫ Leave message with callback number only
- ▫ Consent to mail via postal service
- ▫ Consent to e-mail or fax
    - o Please enter e-mail address _____

With my consent, Avanti Acupuncture, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). *Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures; having the right to review the Notice of Privacy Practices prior to signing this consent.

Avanti Acupuncture, P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Avanti Acupuncture, P.A. of Orlando Privacy Officer at 7575 Dr. Phillips Blvd., Suite #120, Orlando, Fl, 32819. With my consent, Avanti Acupuncture, P.A. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to my clinical care, including lab results; amongst other. With my consent, Avanti Acupuncture, P.A. may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminders, patient statements and laboratory results.

By signing this form, I am authorizing and extending consent to Avanti Acupuncture, P.A. to use and disclose of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

X_____**Date**_____

Signature of Patient or Legal Guardian

Print Name_____