CENTRAL TEXAS
Wellness & Rejuvenation
CENTER
where Health & Beauty come together

HIPAA Notice of Privacy Acknowledgement and Questionnaire

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This notice is provided in two layers. This top layer briefly summarizes how we handle your health information and the attached bottom layer provides further details of our privacy policies and procedures.

How we may use and disclose your health information. We use health information about you for treatment, to be paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax or other methods. We may use or disc lose your health information without your authorization for several reasons. However, beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke this to stop any further uses and discloses.

Your rights in most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health, information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Our legal duty. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. *We may change our privacy policies at any time.* Before we make a significant change in our policies we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.

CTWRC **Phone: (512) 757-8630** **Fax: (512) 757-8630**

Privacy complaints if you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have questions please contact the office manager at (512) 757-8630

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?
(Circle One)

Yes or No

Please indicate if we may contact you via e-mail regarding your scheduled appointment.
(Circle One)

Yes or No

If yes, E-mail address:_____

By signing this form, I freely consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have acknowledgment of receipt of Notice of Privacy Practices. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

_____	_____	_____
Name of Patient	**Signature of Patient**	**Date/Time**
_____	_____	_____
Name of Witness	**Signature of Witness**	**Date/Time**

Please list family members or other persons, if any, whom we may inform about your general medical condition, your diagnosis and any billing questions (including treatment, payment and healthcare operations). As a reminder, these will be the only people we will be able to speak to or release any information to regarding your account or care.

Name: _____ **Phone: _____**

Name: _____ **Phone: _____**