

**KIRKPATRICK
FAMILY CARE**

HIPAA

Kirkpatrick Family Care keeps a record of healthcare services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer (Kathy Hintz). Our Notice of Privacy Practice describes in more detail how your health information may be used and disclosed, and how you can access information.

**BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICE
AND FINANCIAL POLICY**

Patient or Authorized Representative Name: _____ (Relationship) _____

Signature: _____ Date: _____

PHI RELEASE FOR FAMILY MEMBER(S) AND CAREGIVERS

I, _____ give my permission to have my personal health information (PHI) released to the following family members and or caregivers:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

I understand that by signing this agreement, I am giving my permission for the above listed people to discuss my personal health information (PHI). I also understand that this release is valid until revoked in writing.

Patient or Authorized Representative Name: _____ (Relationship) _____

Signature: _____ Date: _____

CANCELATION POLICY

We understand that on rare occasions issues may arise causing you to miss your appointment with our office. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours prior to your appointment to reschedule.

Our highly skilled clinicians are committed to your well-being and have reserved time just for you. Patients who miss more than one appointment without notifying our office 24 hours before the appointment time may be subject to a \$50 missed appointment fee billed to the patient.

Patient or Authorized Representative Name: _____ (Relationship) _____

Signature: _____ Date: _____