***Purity Integrative Health & Wellness Center, PLLC***

**HIPAA ACKNOWLEDGEMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that the below information is correct to the best of my knowledge.

**SHARING OF CONFIDENTIAL INFORMATION**

I give my permission to share any medical information or appointment information to the following person or persons. I authorize the below people to pick up supplements, labs or records on my behalf.

|  |  |  |
| --- | --- | --- |
| NAME | RELATIONSHIP | CONTACT PHONE |
|  |  |  |
|  |  |  |
|  |  |  |

IN CASE OF EMERGENCY

Please contact the following person(s)

|  |  |  |
| --- | --- | --- |
| NAME | RELATIONSHIP | CONTACT PHONE |
|  |  |  |
|  |  |  |
|  |  |  |

**HIPAA**

I hereby certify that I have received & reviewed the *Notice of Privacy Practices*for **Purity Integrative Health & Wellness Center, PLLC**. I understand that if I have objections or concerns with this policy, I must notify **Purity Integrative Health & Wellness Center, PLLC** per the instructions in the *Notice of Privacy Practices*.

**Patient’s or Legal Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s or Legal Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**