Calmglow
FUNCTIONAL MEDICINE

209.247.9170
calmglow.com

HIPPA Acknowledgement Form

I (Print Name)___________________________ understand that as a condition to receiving treatment, my “Provider” may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this practice.

I also understand that I have a right to request the “Provider” to restrict how my health information is used or disclosed. The “Provider” does not have to agree to my request for the restrictions, but if he/she does agree, the “Provider” is bound to abide by the restrictions as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that the “Provider” has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

You may disclose information to the following:

_____________________________ _____________________

Name/Relationship to Patient Phone Number

_____________________________ _____________________

Name/Relationship to Patient Phone Number

_____________________________ _____________________

Patient Signature Date

1120 13th Street, Suite B, Modesto, CA 95354
Monday to Thursday: 9am - 5pm Friday: 9am - 3pm

The information provided is not meant as a replacement for a physician’s care. Some or all of the above may help you feel more balanced and give you an overall increased sense of wellbeing.