Steve Clark ND PLLC

Dr. Steve Clark ND
Dr. Erik O Nelson ND

PATIENT AUTHORIZATION

The purpose of this form is to gain your permission to use your personal health information. Our concern for your confidentiality has not changed. We are required by the federal government to institute several new procedures. In compliance with the new federal regulations of the Health Insurance Portability and Accountability Act (HIPAA) we ask you to consider and approve the following:

Our staff may use your name, address, and/or telephone number for the purpose of contacting you to remind you about scheduled or missed appointments, re-evaluations, or other appointment related issues. We may send out various mailings such as, but not limited to, birthday cards, referral thank-you cards, and newsletters that may contain promotional offers or incentives.

We would like to continue to use your name, address, and/or telephone number for the purpose of contacting you to advise you about health related news, meetings, lectures, seminars, workshops, and other educational events.

We have testimonials submitted by our patients so that others may see the astounding results of continued naturopathic care, and we may ask your permission to participate in this activity. We display artwork created and sometimes signed by children in the waiting room. Patient files are sometimes stacked on the receptionist's desk and a patient's name may be in view; however, there is never any public access to personal information.

We intend to make your experience with our office more efficient, productive, and to further enhance your access to quality health care. You may refuse to sign this authorization. If you chose not to sign it, your decision will have no adverse effect on your care from Dr. Clark, or your relationship with our staff.

I agree with all statements made in this policy with the exceptions written below (if applicable).

Name: (print)_____ Signature: _____ Date:_____

If you are a minor, or being represented by another party:

On what authority do you act on behalf of the patient: _____

Name: (print)_____ Signature: _____ Date:_____

This authorization expires seven years from the date of signature. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw. Please allow 60 days for the change in our system to be completed.