Fundamental Health Solutions

If you are at least 18 years old and would like to give another person (example: spouse, sibling, child, parent) permission to discuss your test results, appointment schedule, or healthcare with Fundamental Health Solutions, please fill out the information below.

DATE: _____

NAME: _____

I _____ give my permission for Fundamental Health Solutions doctors and staff to freely discuss all health information, test results, recommendations and future health concerns with _____.

If I choose to rescind permission for above person to discuss my health status and results, I understand that I must submit this request in writing to Fundamental Health Solutions.

Print Name: _____

Signature: _____

Phil Sledz, DC, DABFM

The Jefferson Bldg
1600 W 38th Street, Suite 120
Austin, TX 78731
Office: (512) 299-1223
(512) 892-4445
Email: change@austinhealthdoc.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

If we make a change to our privacy practices, we will notify you in writing when you come in for care or by email. Please feel free to call us at any time regarding our privacy notices.

I authorize Fundamental Health Solutions to contact me with information related to my personal health needs and interests. This office may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative healthcare options, presentations or events
- Other health related information that may be of interest to me

To contact me, I authorize Fundamental Health Solutions to use and disclose the following information:

- My Name, Address, Email and Phone Numbers
- The Name of my Doctor and the clinic where I was treated

NOTE: HEALTHCARE INFORMATION WILL BE USED OR DISCLOSED.

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Address of Patient: _____ Phone: _____
(STREET)

_____ Email: _____
(CITY, STATE, ZIP CODE)

Fundamental Health Solutions fully supports the protection of health information. Only the doctors in this clinic and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA,this authorization allows us to access only the above authorized information for contact purposes. Failure to sign this authorization will not affect your healthcare, payment or eligibility for benefits in any way.

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing to Fundamental Health Solutions – 1600 W 38th St., Ste. 120 – Austin, Texas 78731. In this case, every effort will be made to discontinue future communications.

_____ _____
Signature (PATIENT OR PERSON AUTHORIZED) Date