EVOLUTIONARY HEALING INSTITUTE
7700 N Kendall Drive, Suite 412, Miami, Florida, 33156
ph: 305.667.8174 fx:305.661.2327

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for practice reminders by:

Mail:________________________ By Voice Mail:________________________

Email:________________________ By Text Message:________________________

Telephone Numbers:________________________ By Facebook Address:________________________

By checking the lines below, I authorize being contacted for birthday greetings or promotions about the practice by:

Mail:________________________ By Voice Mail:________________________

Email:________________________ By Text Message:________________________

Telephone Numbers:________________________ By Facebook Address:________________________

By checking the line below, I authorize the doctor to personally discuss with me products that may benefit my health or condition. ________________________

________________________________ ________________________
Patient Name (Printed or Typed) Date

____
Parent, Guardian or Patient's Legal Representative

____
Signature of Patient, Guardian or Patient's Legal Representative

List below the names and relationship of people to whom you authorize the Evolutionary Healing Institute to release PHI:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Please save this form and email to ehmiami@gmail.com
You will be asked to sign at the office.