

ELLERY PANAI A III, DC
1299 BRACE ROAD
CHERRY HILL, NJ 08034
PHONE 856-795-2424
FAX 856-795-2212

Dear Patient:

Please be advised that we are required by law to maintain the privacy of and provide individuals with notice of our legal duties and privacy practice with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practice.

Signature: _____ Date: _____

Print Patient Name: _____

In accordance with new federal regulations regarding patients' privacy, please read and sign the following:

I, _____ give permission to Ellery Panaia III, DC to do the following:

- Confirm appointments by phone
- Leave messages on answering machine to confirm appointments
- Release medical information requested by another treating physician or health institution.
- Give permission for Ellery Panaia III, DC to request records as needed from other physicians and/or institutions to assist in my ongoing treatment.

The following person is authorized to receive medical information about me, the patient in the event, that I cannot be available.

Contact Name: _____

Phone # _____ Relationship to contact: _____

Patient Signature: _____ Date: _____