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## HIPPA Compliance

I release Charny Healing Center and Dr. Charny from HIPAA compliance and give her permission to share information about me with her staff and others whenever she feels it is necessary and appropriate to support my care, to work with others who may be involved with my care, to increase my likelihood of being reimbursed, to protect her interests, for office purposes, or when required to do so by law.

I fully understand and agree to the above policies and fees.

I request care from Dr. Charny and her staff.

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Patient's Contact Number: \_\_\_\_\_

Guardian's Name if Patient under 18: \_\_\_\_\_

Guardian's Contact Number: \_\_\_\_\_

Patient's or Guardian's Signature: \_\_\_\_\_