

Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to VIDA Chiropractic Studio to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to VIDA Chiropractic Studio to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
- If VIDA Chiropractic Studio contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to VIDA Chiropractic Studio to use my name on a welcome board, referral board, and birthday board.
- I give permission to VIDA Chiropractic Studio to use my photograph on their bulletin board and other informational material such as their brochure, website, and articles in print media.
- I give permission to VIDA Chiropractic Studio to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, on their website, or in ads in print media.
- I give VIDA Chiropractic Studio permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.
- By signing this form you are giving VIDA Chiropractic Studio permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your experience at VIDA Chiropractic Studio more efficient and productive as well as to enhance your access to quality Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at the VIDA Chiropractic Studio plus 7 years or until revoked by me.

(over)

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the VIDA Chiropractic Studio. The written notice must contain the following information:

- Your name, Social Security number, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature

The revocation is not effective until it is received by VIDA Chiropractic Studio.

This AUTHORIZATION is requested by VIDA Chiropractic Studio for its own use / disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, VIDA Chiropractic Studio will provide care , however, it will not be possible for VIDA Chiropractic Studio to file third party billing on my behalf and I will be responsible for: 1) payment in full at the time services are provided to me 2) scheduling my own appointments since VIDA Chiropractic Studio will be unable to contact me 3) all contact with VIDA Chiropractic Studio regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, with boundaries, the Protected Health Information to be used / disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ D.O.B.: _____ / _____ / _____

My Name (Print): _____

My Signature: _____

Today's Date: _____ / _____ / _____

Name of Personal Representative (If someone other than yourself is designated to act on your behalf)

Name (Print): _____

Signature of Personal Representative: _____

Description of Representative's Authority To Act On your Behalf: _____
