HEALTH CARE AUTHORIZATION FORM

I have been provided with Notice of Privacy Practices for Protected Health Information. This describes the uses & disclosures that will occur in my care, payments, or processes of this practice.

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 Dr. Lori to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

1. I give permission to Dr. Lori to use my email and/or phone number to contact me with appointment reminders, missed appointment notification, email newsletters and any other pertinent information regarding my health and wellness. If Dr. Lori contacts me by phone, I give her permission to leave a phone message.
2. I give permission to Dr. Lori to use any testimonial or photo of myself to share with other practice people or potential practice people.
3. I give Dr. Lori permission to Entrain me in an open room where other practice people are also being Entrained. I am aware that other persons may overhear some of my protected health information. If I need to speak with Dr. Lori in private, she will provide a room for this.
4. By signing this form I am giving Dr. Lori permission to use and disclose your protected health information in accordance with the directives listed above.

This authorization remains in effect for the duration of my care or for 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You can revoke this AUTHORIZATION, in writing, at any time. Your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services.

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 effective when it is received by Dr. Lori

I have the right to inspect or copy 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 Healthcare Authorization Form. I acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature represents agreement with this.

SSN:________________________________ DOB:____________________

Patient’s name (please print): ____________________________________

Patient’s Signature: _____________________________________

Today’s Date: ________________________

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):________________________________

Signature:____

Description of Representative’s Authority to Act on Patient’s Behalf:______________________

____