HEALTHCARE AUTHORIZATION FORM

Patient's Name ______________________________

Patient's SS# ______________________ **Date of Birth** ______________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES COMPLETE HEALTH & CHIROPRACTIC CENTER TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to **COMPLETE HEALTH & CHIROPRACTIC CENTER** to use my address, phone number, and clinical records to contact me with birthday card, holiday related cards and information about treatment alternatives or other health related information.
- ❑ I give **COMPLETE HEALTH & CHIROPRACTIC CENTER** permission to treat me in an open room where other patients are also being treated. 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 doctor at any time in private, the doctor will provide a room for these conversations.
- ❑ By signing this form you are giving **COMPLETE HEALTH & CHIROPRACTIC CENTER** permission to use and disclose your Protected Health Information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: **Until Revoked by Patient**.

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 Privacy Official of **COMPLETE HEALTH & CHIROPRACTIC CENTER**. 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
- Your signature

The revocation is not effective until it is received by the Privacy Official.
This Authorization is requested by **COMPLETE HEALTH & CHIROPRACTIC CENTER** for its own use/disclosure of Protected Health Information (PHI).
(Minimum necessary standards apply)
You have the right to refuse to sign this Authorization. If you refuse to sign this Authorization, **COMPLETE HEALTH & CHIROPRACTIC CENTER** will not refuse to provide treatment. You have the right to inspect or copy the Protected Health Information (PHI) to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU.

PATIENT'S SIGNATURE ______________________________ **DATE** __________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

PATIENT'S SIGNATURE ________________________________ DATE ____________

COMPLETE HEALTH & CHIROPRACTIC CENTER

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