HEALTH CARE AUTHORIZATION FORM

This serves as notice that Everybody's Chiropractic Center, it's employees and outside contractors are in compliance with federal guidelines regulating patient privacy.

Patient's Name: _____

Patient's SS#: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **EVERYBODY'S CHIROPRACTIC CENTER** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to **EVERYBODY'S CHIROPRACTIC CENTER** to use my address, phone number, e-mail address and clinical records to contact me with birthday cards, holiday related cards, newsletters and information about treatment alternatives or other health related information.

- ❑ I give permission to **EVERYBODY'S CHIROPRACTIC CENTER** to use my name on sign in sheets, and "patient of the week" award certificates, should the occasion arise. X-rays, personal and family photographs and patient testimonials documenting the many successes of chiropractic care may also be displayed with the patient's permission.

- ❑ I give **EVERYBODY'S 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.

- ❑ I give **EVERYBODY'S CHIROPRACTIC CENTER** permission to obtain any testing results and/or medical records on my behalf.

EXPIRATION

This authorization will expire seven years after the date on which you last received services from us.

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 EVERYBODY'S CHIROPRACTIC CENTER. The hand 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 the Privacy Official.

This authorization is requested by Everybody's Chiropractic Center for its own use/disclosure of PHI. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, EVERYBODY'S CHIROPRACTIC CENTER will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

a copy of the signed authorization will be provided to you

_____
Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Personal Representative Date

_____
Description of Representative's Authority to Act for Patient