HEALTH CARE AUTHORIZATION FORM

Patient's Name_____

Patient's SS#_____ Date of Birth_____
THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Abundant Life Chiropractic** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- I give permission to **Abundant Life Chiropractic** 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 alternatives or other health related information.
- If **Abundant Life Chiropractic** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give **Abundant Life Chiropractic** 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 **Abundant Life Chiropractic** permission to disclose protected health information during my Report of Findings to myself and whoever I chose to take in the report room with me.
- By signing this form you are giving **Abundant Life Chiropractic** permission to use and disclose your protected health information in accordance with the directives listed above.

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 in 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 **Abundant Life Chiropractic.** The written notice must contain the following information:
Your name, Social Security #, 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 received by the Privacy Official.
This AUTHORIZATION is requested by **Abundant Life Chiropractic** for its own use/disclosure of PHI. (Minimum necessary standards apply)

You have the right to refuse this AUTHORIZATION. If you refuse this AUTHORIZATION, **Abundant Life Chiropractic** 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 for you.

Print Name of Patient_____

Signature of Patient_____Date_____

Signature of Parent or Legal
Guardian_____Date_____