

HEALTH CARE AUTHORIZATION FORM (HIPPA)

Patient's Name (Last, First Middle): _____

Patient's D.O.B.: _____

Date: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ROBERTS CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIAL AUTHORIZATIONS

1. I give permission to Roberts Chiropractic to use my address, phone number, e-mail address and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
2. I give Roberts 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 closed room for these conversations.
3. By signing this form, you the patient, are giving Roberts Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

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

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 Roberts Chiropractic. The written notice must contain the following information:

1. Your name.
2. Your social security number.
3. Your date of birth.
4. A clear statement of your intent to revoke this AUTHORIZATION.
5. The date of your request.
6. Your signature.

This revocation is not effective until it is received by the Privacy Official.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Roberts Chiropractic will not refuse treatment. However, if you refuse to sign the AUTHORIZATION, it will be necessary for you to sign the bottom of the page. This is your acknowledgement that you were presented with and understood this information, yet choose to refuse the AUTHORIZATION.

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 AT YOUR REQUEST

AGREEMENT TO SIGN HIPPA_____
(Patient Name Printed)_____
(Patient Signature)_____
(Signature of parent or guardian if
patient is a minor)**REFUSAL TO SIGN HIPPA**_____
(Patient Name Printed)_____
(Patient Signature)_____
(Signature of parent or guardian if
patient is a minor)