Health Care Authorization Form

Patient's Name _____

_____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES THE OFFICE OF **SHENANDOAH CHIROPRACTIC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

[✓] I give permission to the office of Shenandoah 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 treatment alternatives or other health related information.

[✓] If the office of Shenandoah Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

By signing this form I am giving the office of Shenandoah Chiropractic permission to use and disclose my 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 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 the office of Shenandoah Chiropractic. 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 not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by the office of Shenandoah Chiropractic for its own use/disclosure of PHI (protected health information). *(Minimum necessary standards apply.)* You have the right to inspect or copy the PHI to be used/disclosed.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, the office of Shenandoah Chiropractic will not refuse to provide treatment.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST

Print Name of Patient: _____

Signature of Patient: _____ Date: _____

Signature of Personal Representative: _____