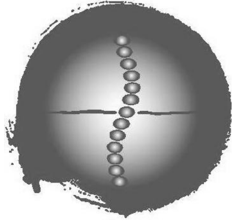

INTEGRAL CHIROPRACTIC CENTER

Protected Health Information Authorization

Patient Name: ________________________________ Date of Birth: ______________

The patient identified above authorizes Integral Chiropractic Center to use and or disclose protected health information in accordance with the following:

Specific Authorizations

q I give permission to Integral Chiropractic Center to use my address, e-mail, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

q I give Integral 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 doctor at any time in private; the doctor will provide a room for these conversations.

q I give Integral Chiropractic Center permission to post any pictures or testimonials of myself or my family that I should give to them. I further understand that any picture or testimonial I write and attach my name to may be posted in a public waiting room, in clear sight of anyone who may enter the room.

q I give Integral Chiropractic Center permission to disclose your protected health information to a third party such as an insurance carrier, HMO, PPO, or my employer, in order to obtain payment for services.

q By signing this form you are giving Integral Chiropractic Center permission to use and disclose your protected health information in accordance with the directives listed above.

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Privacy Practices for Protected Health Information 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, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Patient Signature: ________________________________ Date: ________________

Please see reverse side

At Post Riverside v 4403 Northside Parkway, Suite #1101 v Atlanta, Georgia 30327
Phone: 404.233.3386 v Fax: 404.233.3186
www.IntegralChiropractic.com

Right to Refuse Authorization

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Integral Chiropractic Center will not refuse to provide treatment.

- [ ] I refuse to sign this authorization

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 Integral 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 Integral Chiropractic Center for its own use/disclosure of Protected Health Information. (Minimum necessary standards apply.)

You have the right to inspect or copy the Protected Health Information to be used and or disclosed.

A copy of this signed authorization will be provided to you at your request

Patient Name: ______________________________ Date: ______________

Patient or Guardian Signature: ____________________________________

Expiration

The Authorization shall expire on the following date: ______________________