HEALTHCARE AUTHORIZATION FORM

Patients Name: _____
Patients S.S. #: _____ Date of Birth: _____
THE PATIENT IDENTIFIED ABOVE AUTHORIZES ALLIANCE CHIROPRACTIC AND MASSAGE TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Alliance Chiropractic and Massage to use my address, phone number, e-mail and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
- I give Alliance Chiropractic and Massage 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.
- By signing this form you are giving Alliance Chiropractic and Massage 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** is not effect 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 Alliance Chiropractic and Massage. 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 in effect until it is received by the Privacy Official.

This **AUTHORIZATION** is requested by Alliance Chiropractic and Massage 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,** Alliance Chiropractic and Massage 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*****

PRINT NAME OF PATIENT: _____
SIGNATURE OF PATIENT: _____
DATE: _____
Signature of Personal Representative: _____
Description of Representative's Authority to Act for Patient: _____