CHIRO4SPORTS HIPAA COMPLIANCE

Patient's Name_____ Date of Birth_____

The patient identified above authorizes CHIRO4SPORTS to use and/or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATIONS

- I give CHIRO4SPORTS permission to use my address, phone numbers, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, and information about treatment alternatives or other health related information.

- I give CHIRO4SPORTS permission to share my testimonial, include my name on the "Congratulations/Thank you" board and display my picture.

- I give CHIRO4SPORTS 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 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 CHIRO4SPORTS permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date:_____

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 Chiropractic*USA*. 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 the Privacy Official receives it.

CHIRO4SPORTS requests this AUTHORIZATION for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

You have the right to refuse this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Chiropractic*USA will not refuse to provide treatment.*

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

PLEASE FILL IN ALL AREAS IN BOLD

*** A COPY OF THE SIGNED AUTHORIZATION CAN BE PROVIDED TO YOU***

Printed Name of Patient:_____ **Today's Date:**_____

Signature of Patient/Guardian:_____ **Relationship:**_____

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My signature acknowledges that I have received a copy of CHIRO4SPORTS' Notice of Privacy Practices:

Signature of Patient/Guardian:_____