COUNTRY ROADS

Mobile Chiropractic

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HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Country Roads Mobile Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

Please mark with an X if you are **NOT** okay with these authorizations.

- I give permission to CRMC to use my address, phone number and clinical records to contact me with appointment reminders or missed appointment notification.
- I give CRMC permission to send me birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If CRMC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to CRMC to use my name on a welcome board, referral board, and birthday board.
- I give permission to CRMC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to CRMC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give CRMC 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.
- By signing this form you are giving CRMC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at CRMC plus 7 years or until revoked by me.

(over)

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 CRMC. 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 CRMC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, ____ will not refuse to provide treatment however, it will not be possible for CRMC to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since CRMC will be unable to contact me 3) all contact with CRMC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN:_____ DOB:_____

Patient's name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):_____

Signature:_____

Description of Representative's Authority to Act on Patient's Behalf:_____

_____