

By signing below I acknowledge receipt of a Notice of Information Practices 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.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## HEALTH CARE AUTHORIZATION FORM

Patient's Name \_\_\_\_\_

Patient's SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Wards Corner Chiropractic, Inc.** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

### SPECIFIC AUTHORIZATIONS

- I give permission to **Wards Corner Chiropractic, Inc.** to use my address, phone number and clinical records to contact me with birthday cards, thank you cards, holiday related cards, newsletters, testimonials, list my name on the New Patient board, and contact me about treatment alternatives or other health related information.
- I give **Wards Corner Chiropractic, Inc.** permission to display any pictures that I give them of myself or my children on the picture wall.
- I give **Wards Corner Chiropractic, Inc.** 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.
- I give **Wards Corner Chiropractic, Inc.** permission to combine any mailings with my spouse. I, also, give my spouse permission to call for and cancel my appointments.

**EXPIRATION:** The Authorization shall expire on the following date: \_\_\_\_\_

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 Wards Corner Chiropractic, Inc.. The written notice must contain the following information: Your name, Social Security number, 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 **Wards Corner Chiropractic, Inc.** 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, **Wards Corner Chiropractic, Inc.** 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 UPON REQUEST\*

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Description of Representative's Authority To Act for Patient