HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Pontoriero Chiropractic Center** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

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

- ❑ I give **Pontoriero 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.

- ❑ By signing this form you are giving **Pontoriero Chiropractic Center** 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: **April 1, 2023**

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 **Pontoriero 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; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **Pontoriero Chiropractic Center** 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, **Pontoriero Chiropractic Center)** 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 * *

Name of Patient _____
(Print)

Signature of Patient _____

Date _____

If Applicable:

Signature of Parent or Guardian _____

(Parent or Guardian or Other) _____