TOMPKINS FAMILY CHIROPRACTIC

1485 Peachtree Parkway
Suite D-7
Cumming, Georgia 30041
Phone (770) 888-9027
Fax (770) 888-9028

671 Lumpkin Campground Rd.
Suite 20
Dawsonville, Georgia 30534
Phone (706) 265-7017
Fax (706) 265-8276

HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____

Patient's SS#: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **TOMPKINS FAMILY CHIROPRACTIC** TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **Tompkins Family Chiropractic** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, and information about treatment alternatives or other health related information.
- If **Tompkins Family Chiropractic** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give **Tompkins Family Chiropractic** permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.
- I give **Tompkins Family Chiropractic** 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 **Tompkins Family Chiropractic** permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION: The authorization shall expire upon your request.

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 **Tompkins Family Chiropractic**. *The written notice must contain the following information: Your name, SS# 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 the Privacy Official receives it.

This AUTHORIZATION is requested by **Tompkins Family Chiropractic** 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, **Tompkins Family Chiropractic** will not refuse to provide treatment.

You have a right to inspect or copy the PHI to be used / disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON YOUR REQUEST

Print Name of Patient: _____ Date: _____

Signature of Patient or Legal Guardian: _____

FOR OFFICE USE ONLY:

Signature of Personal Representative: _____

Description of Representative's Authority to Act for Patient: _____