HEALTH CARE AUTHORIZATION FORM

_____

Patient's Name

_____ _____

Patients SS# Date of Birth

THE PATIENT IDENTIFIED ABOVE AUTHORIZES *Dr. Katina V. Manning, Dr. Amanda E. Halstead d.b.a. Wellspring Chiropractic* TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ✓ I give *Wellspring 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 in private, the doctor will provide a room for these conversations.
- ✓ I agree to an open appointment book policy. Therefore, I will participate in entering my name into the appointment book for the purpose of booking an appointment. I understand and accept that other patients may view my name.
- ✓ I understand on occasion Preceptor Chiropractor or Medical Students may come in to observe patients during treatment hours.
- ✓ By signing this form you are giving *Wellspring Chiropractic* permission to use and disclose your protected health information to any insurance company and/or health care providers that the patient is interacting with.

Wellspring Chiropractic requests this AUTHORIZATION for its own use/disclosure of Protected Health Information (PHI).
You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, ***Wellspring Chiropractic*** has the right to 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 IF YOU REQUEST ONE

_____ _____

Print Name of Patient Signature of Patient

_____ _____

Signature of Personal Representative Description of Representative's Authority To Act for Patient or Guardian

EXPIRATION

The Authorization does not expire

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 *Wellspring Chiropractic*. 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 the Privacy Official receives it.