

Authorization to Disclose Health Information to Family members and friends

Patient Name _____ Date of birth _____

I hereby authorize CHIROsport & Spine, LLC ("CSS") to release my patient health information as described below:

		Type of Information Allowed to Disclose (Check one or Both)		Method of Disclosure (Check one or both)	
Name	Relationship	Medical	Billing	By Phone	In Person

Protected Health Information ("PHI") may include information/documents regarding chiropractic/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPPA") govern the terms of this authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation must include my name, address, telephone number, date of this authorization and my signature; and that I should sent it to the attention of the "HIPPA Compliance Officer"

I understand that I am not required to sign this Authorization and the CSS may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that, will no longer be protected by HIPPA.

[Check One] I DO ___ DO NOT ___ GIVE PERMISSION to CHIROsport & Spine LCC, to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPPA guidelines allow for basic information regarding appointments [time, date, location] to be left on the answering machine or with family members.

HIPPA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of CSS. Other than those releases authorized by HIPPA, PHI will only be released to persons listed on this authorization, If you choose not to authorize any family members or friends for disclosure of PHI, CSS will not be able to release any information, including appointment or patient billing questions to anyone on than the patient.

Signature of Patient or Personal Representative (i.e. Guardian) _____

Relationship of Personal Representative to Patient _____

Date of Authorization: _____