

First Choice Chiropractic

Privacy Policy

Patient Authorization for the Use and Disclosure of Protected Health Information

1. I have been presented a copy of the First Choice Chiropractic Notice of Privacy Policy.
2. I am aware that I can contact the Privacy Officer at any time regarding any questions I may have concerning the First Choice Chiropractic Notice of Privacy Policy.
3. I understand I can request a limitation to the disclosure of my protected health information at any time in writing.
4. I expressly acknowledge that this authorization is voluntary.
5. I understand I may get a copy of this request after I sign it.
6. I understand that the information used or disclosed pursuant to this authorization, may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
7. I hereby authorize First Choice Chiropractic to use and/or disclose my protected health information in accordance with the procedures outlined in the First Choice Chiropractic Notice of Privacy Policy.

Name of patient _____
(please print)

Signature _____
of patient or legal guardian if patient is under 18 or otherwise unable to sign for himself/herself.

Date of authorization _____
(authorization expires three years from date above)