

Health Care Authorization

Patient's Name _____

Social Security # _____ Age _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHOURIZES **EAST PAULDING CHIROPRACTIC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

I give permission to **East Paulding Chiropractic** (EPC) to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, related cards (welcome, thank you, congratulatory, sympathy, etc.) or other health related information. I also give my permission to use my name and photo in testimonial format (if applicable), or to use my child's photo and/or name on a children's wall (if applicable).

If VFC contacts me by phone, I give them permission to leave a phone message on my answering machine or with a family member taking a message personally or by voice mail.

I give Dr. Kent D. Vanderslice permission to treat me in a semi-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 give EPC / Dr. Kent D. Vanderslice permission to use my first name and overall case outcome (if applicable), when relaying experience and educational information to another patient.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their patient Health Information. Our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of the these policies and procedures.

If a patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

By signing this form I am giving East Paulding Chiropractic permission to use and disclose my protected health information in accordance with the directives listed above.

This authorization shall remain in effect unless revoked in writing by the patient.

Signature of patient _____ Date _____

Witness _____ Date _____