McALPINE
CHIROPRACTIC GROUP

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to McAlpine Chiropractic Group to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to McAlpine Chiropractic Group to use my address, email, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If McAlpine Chiropractic Group contacts me by phone, I give them permission to leave a text message and/or phone message on my answering machine or voice mail.
- I give permission to McAlpine Chiropractic Group to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give McAlpine Chiropractic Group 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 doctor at any time in private, the doctor will provide a room for these conversations.

This form is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at McAlpine Chiropractic Group plus 7 years or until revoked by me.

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 McAlpine Chiropractic Group. 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.**

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, McAlpine Chiropractic Group will not refuse to provide treatment however, it will not be possible for McAlpine Chiropractic Group to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since McAlpine Chiropractic Group will be unable to contact me 3) all contact with McAlpine Chiropractic Group regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient Name (please print): _____ **DOB.:** _____

Patient's Signature: _____ **Date:** _____

For Office Use Only

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practice, but Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the Acknowledgement
- ☐ An emergency situation prevented us from obtaining Acknowledgement
- ☐ Other (please specify) _____

Staff Signature: _____ Date: _____