HIPAA Authorization Form

Full Name: _____ Date of Birth:_____

Address: _____

Purpose & Authorization to Disclose Information:
I authorize Jubilee Family Chiropractic to disclose my protected health information (PHI) to the following purposes to the following individuals or entities:

Treatment: To provide chiropractic treatment and related services to me.
Payment: To bill and collect payment for the chiropractic services provided to me.
Healthcare Operations: To conduct administrative activities necessary for the operation of the chiropractic office, such as quality assessment, training, and compliance activities.

Other healthcare providers involved in my treatment, Insurance companies for billing and payment purposes
Business associates who perform services on behalf of the chiropractic office
Family members or other individuals involved in my healthcare

Other (please specify): _____

Pick One:
___ I hereby authorize the use of my first and last name within the office premises for treatment purposes.
___ I DO NOT authorize the use of my first and last name within the office premises for treatment purposes. In place of first and last name, I request the calling system to use: _____

Expiration & Revocation of Authorization:
This authorization expires three years after discontinuation of care, after which time Jubilee Family Chiropractic will no longer use or disclose my protected health information (PHI) for the above purposes. I understand that I may revoke this authorization at any time by submitting a written request to Jubilee Family Chiropractic, except to the extent that action has already been taken based on this authorization.

Rights and Confidentiality:
I understand that I have the right to inspect and copy my protected health information (PHI) maintained by Jubilee Family Chiropractic, as well as the right to request amendments to my PHI if I believe it is inaccurate or incomplete. I understand that my protected health information (PHI) will be kept confidential and will not be disclosed to any other party except as required or permitted by law.

Acknowledgement:
By signing below, I acknowledge that I have read and understood the information provided above, and I authorize Jubilee Family Chiropractic to use and disclose my protected health information (PHI) as described in this form.

Signature: _____ Date: _____