3450 Acworth Due West Rd., NW ▪ Suite 330 ▪ Kennesaw, GA 30144
678-574-5227 ▪ fax 678-574-5223

HEALTH CARE AUTHORIZATION FORM

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.

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

SPECIFIC AUTHORIZATIONS:

- I give permission to BIFC to use my address, 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 information.

- If BIFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

- I give BIFC permission to discuss my medical information with the following person(s):

  1. ____

  2. ____

- For clinical purposes, visits may be audio recorded for the Doctor's use only. You will be notified when the visit will be recorded.

- I give permission to BIFC 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.

- By signing this form you are giving BIFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Big Idea Family Chiropractic plus 12 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 extent that we have provided services or taken action in reliance on your authorization.

3450 Acworth Due West Rd., NW ▪ Suite 330 ▪ Kennesaw, GA 30144
678-574-5227 ▪ fax 678-574-5223

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of BIFC. 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.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by BIFC for its own use/disclosure of PHI. (*minimum necessary standards apply)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, BIFC will not refuse to provide treatment however, it will not be possible for BIFC 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 BIFC will be unable to contact me 3) all contact with BIFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign this authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me upon request.

HEALTHCARE AUTHORIZATION

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

My name (please print): ____

My signature: ____

Today's date: ____________________________

Name of personal Representative (if someone is designated to act on your behalf)

Name (please print): ____

Signature of Personal Representative: ____

Description of Representative's Authority to Act on Patient's Behalf: _________________________________

____