

## Health Care Authorization Form

Patient's Name \_\_\_\_\_

Patient's SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **CHIROHEALTH ROCKFORD** TO USE AND \_\_\_\_\_  
OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

### SPECIFIC AUTHORIZATIONS

- I give permission to **ChiroHealth Rockford** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards information about treatment alternatives or other health related information.
- If **ChiroHealth Rockford** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- By signing this form you are giving ChiroHealth Rockford permission to use and disclose your protected health information in accordance with the directives listed above.

### EXPIRATION

The Authorization shall expire on the following date: \_\_\_\_\_

### 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 I reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of **ChiroHealth** Rockford.

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 receive by the Privacy Official.

This Authorization is requested by (ChiroHealth Rockford) for its own use/disclosure of PHI. (Minimum necessary standards apply.)

You have the right to refuse to sign this Authorization. If you refuse to sign this authorization, (ChiroHealth Rockford) will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

\*\*\* Upon request, a copy of the signed authorization will be provided to you \*\*\*

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Description of Representative's Authority to Act for Patient