

# McClellan Chiropractic Clinic P.C.

3731 Rainbow Drive, Suite A

Rainbow City, AL 35906

Ph: 256 442-1441 Fax: 256- 442-3938

## HEALTH CARE AUTHORIZATION FORM

Patient's Name \_\_\_\_\_ ID# \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES McClellan Chiropractic Clinic P.C. TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

### SPECIFIC AUTHORIZATIONS

- I give permission to McClellan Chiropractic Clinic P.C. to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
  
- I give McClellan Chiropractic Clinic P.C. 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.
  
- By signing this form you are giving McClellan Chiropractic Clinic P.C. permission to use and disclose your protected health information in accordance with the directives listed above.

## **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 McClellan Chiropractic Clinic P.C. 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 McClellan Chiropractic Clinic P.C. for its own use/disclosure of PHI.

*(Minimum necessary standards apply.)*

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

- \* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU \*\*

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

Date: \_\_\_\_\_

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

Description of Representative's Authority To Act for

Patient: \_\_\_\_\_