complete chiropractic
1101 E. 51ST STREET
SAVANNAH GEORGIA
912.354.6767 FAX 912.353.7431
www.completechiropractics.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I,_____hereby authorize Complete Chiropractic to use and/or disclose to my general health practitioner, my referring physician, my attorney, my spouse and/or other family members the following specific health information: (Please check the appropriate boxes)

_____Complete Medical Record _____ X-Ray Reports _____Other

2. I understand this authorization is valid for five years from the date signed or until I revoke it in writing.

3. Please list anyone that you DO NOT want your protected health information disclosed to:

_____

4. I acknowledge this authorization is voluntary.

5. I understand the authorizer may revoke this authorization in writing at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have an effect on disclosures occurring prior to the execution of any revocation.

6. I understand the information used or disclosed pursuant to this the recipient may be subjected to disclose authorization again. This information will no longer be protected by federal privacy regulations.

7. I understand my health care and payment for my healthcare will not be affected if I do not sign this form.

8. I understand t I may get a copy of this form after I sign it, if I ask for it.

9. I certify all of my questions were answered to my satisfaction, and I understand this authorization form and all of its contents.

Month of _____Day of _____Year of_____

_____ _____
Patient Name Patient Signature

_____ _____
Signature of Legal Representative Relationship