BURKHART & CHAPP CHIROPRACTIC PLC

Innovative Health Care Solutions

HIPAA Authorization

Patient Chart #: _____

Patient Name: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____

By signing below, I acknowledge that in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, that I have the right to revoke this consent, in writing, except to the extent that Burkhart & Chapp Chiropractic (BCC) has taken action in reliance on this consent.

With this consent, BCC can call me at home or an alternate location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations (TPO), such as appointment reminders, obtaining insurance information, billing, and any calls pertaining to my clinical care. Burkhart & Chapp Chiropractic also has my consent to mail any items that assist the practice in carrying out TPO, such as appointment cards, statements, and insurance information. I am consenting to BCC, the use of my Protected Health Information (PHI) to carry out the TPO.

I also understand that BCC will uphold the privacy of my medical records unless this information is requested to be released by myself or someone who I have given permission to access my records. I am also fully aware that Burkhart & Chapp Chiropractic will not share my medical records with anyone without an authorization, except in the event of an emergency or patient's condition that deems the situation medically necessary.

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: _____Relationship:_____Phone#: _____

Name: _____Relationship:_____Phone#: _____

By signing my name below, I acknowledge my understanding of the terms of this agreement. This authorization shall supersede any prior written authorization I have made regarding the use, disclosure, and release of my medical information. This authorization will expire 2 years from the date it is signed.

_____ Date:_____

Signature of Patient or Personal Representative

Official Use Only:
Scanned _____ EMR Entry _____
Patient Signature Date (e-Thomas)_____

Revised PN 12/15/2016