Premier Sports Chiropractic

Health Insurance Portability and Accountability Act (HIPAA)

AUTHORIZATION FOR USE OF HEALTH CARE INFORMATION:

In the course of your care we may use in the following ways:

- Your personal health information, including your clinical records and billing information, may be disclosed to another health care provider, insurance carrier for further diagnosis, or payment of services.

Under Federal Law, we are also permitted and required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency situation.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers in communicating with you, but in our professional judgment we believe that you intend for us to provide care for you.
- If we are ordered by the courts or another appropriate agency.

You have the right to inspect and/or copy your health information for a period of seven years. You have a right to amend the information in your file provided a request is submitted in writing.

AUTHORIZATION FOR CONTACT REGARDING CHIROPRACTIC CARE RELATED TO HEALTH SERVICES AND/OR HEALTH PRODUCT:

It is our desire for our staff to use your name, address and / or telephone number for the purpose of contacting you to advise you about future appointments, workshops, and products.

PATIENT AUTHORIZATION FOR REFERRALS, BIRTHDAYS, THANK YOU CARDS AND TESTIMONIALS:

It is our desire for our staff to post your name in appreciation for referring patients to our office. To show our thoughtfulness, we may send birthday and thank you cards when appropriate. If you respond favorably to chiropractic care, you may be asked to fill out a "patient testimonial," you may decline if you wish. This will help others read the success of chiropractic. Your picture may be posted on our testimonial board or in our testimonial book or website.

The use of this information mentioned in the above three sections is intended to make your experience with our office more efficient and productive.

If you choose not to authorize this information, your decision will have no adverse effect on your care from our office or on your relationship with our staff.

OPEN ADJUSTMENT ENVIRONMENT:

Our office is an open adjusting environment. Your consultations, examinations, scans, x-rays, and report of findings are preformed in the privacy of a closed room. Conversations between you, your doctor, and the staff during normal treatments may be overheard by others in the office. Our goal is to maintain as much privacy as possible. If you are uncomfortable discussing your case, you may request a private consultation for your next visit.

Your signature indicates you have read, understood, and authorize the above activities.

_____	_____	____ / ____ / _____
Printed Name of Patient	**Signature**	**Date**

If you are under the age of 18, you must be represented by a parent or guardian.

_____	_____	____ / ____ / _____
Printed Name of Parent / Guardian	**Signature**	**Date**

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of you desire to withdraw your authorization. Please allow a reasonable amount of time for the change in our system to be completed.