

AUTHORIZATION TO USE AND DISCLOSE HEALTHY INFORMATION

The Healthy Back Clinic

(336)629-0086

INDIVIDUAL PATIENT

I give my authorization to use or disclose my protected health information.

YOUR NAME _____

Legal responsibility

Are you 18 years or older and legally responsible for yourself? Y N

If you are a child or a teenager please list the name of the parent or guardian who has custody over you. _____

THE USE AND/OR DISCLOSURE

I understand that under the HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse who is involved with your insurance claims fulfillment.

Under these new regulations the following people must be authorized by you to have access to your health information: your spouse, other family members and friends; nurse or home aid; legal guardian; or other person/organization who is not involved with your medical treatment, insurance plan, or payment.

Please list the people/organizations that you authorize to have access to your information:

Name: _____ Phone: _____

Address: _____ Relationship to patient: _____

CHANGING YOUR MIND ABOUT AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer.

METHOD OF CONTACT

I authorize the office of The Healthy Back Clinic to contact me in the following manner:

Home telephone OK to mail to my home address
 OK to leave message OK to mail my work/office address
 OK to fax OK to call work

STATEMENT OF UNDERSTANDING

I have reviewed and I understand the Authorization. I also understand that my healthy information will be used or disclosed to certain business associates of The Healthy Back Clinic who are part of the health care process.

These business associates will keep your information confidential.

By: _____ **Date:** _____

(Patient)