



Patty Long, D.C., F.I.C.P.A
 12036 Hwy 231-431 N, #A
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 256-828-2236

Authorization to Use or Disclose Protected Health Information

Patient Last Name: _____ Patient First Name, MI _____
 Address _____ City _____ State _____ Zip _____
 Date of Birth _____ Date of Request _____

As required by the Privacy Regulations, Long Chiropractic may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following persons(s), entity(s), or business associates of this office:

Patient Health Information authorized to be disclosed: _____

For the specific purpose of (describe in detail): _____

May we leave messages:

- On answering machine at home? On answering machine at work?
- With spouse/family member?
- Fax information to you regarding appointments or records? Fax #: _____

Special Support Sessions: As part of our office policies we will ask that your spouse attend certain special appointments with you as your support. If single, we will ask a friend or family member to attend. This request is made in an effort to better serve you. During these appointments, your friends or family members may become aware of your health conditions.

Long Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Effective dates for this authorization ____/____/____ through ____/____/____
 this authorization will expire at the end of the above period.

 Signature of Patient or Patient's Authorized Representative

 Date

 Authorized Signature of Facility

 Date