

Heart of Dixie Chiropractic

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Heart of Dixie Chiropractic** TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I permit **Heart of Dixie Chiropractic** to use my address, phone number and clinical records to contact me with information about my treatment alternatives, missed appointments or other health-related information.

THERAPY ROOM AUTHORIZATION

I permit Heart of Dixie Chiropractic to treat me with modalities in an open room where other patients are also being treated. I understand that, while getting therapy, I will have curtains that give limited privacy. I am aware that other persons in the office may overhear some of my protected health information during the course of care. If I need to speak with the doctor in private at any time, the doctor will provide a room for these conversations. By signing this form, you are giving **Heart of Dixie Chiropractic** permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire 2 years from today unless otherwise requested.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official for **Heart of Dixie Chiropractic**. The written notice must contain the following information: Your name, Social Security Number, and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and your signature. The revocation is not effective until the Privacy Official receives it. This AUTHORIZATION is requested by **Heart of Dixie Chiropractic** for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **Heart of Dixie Chiropractic** will refuse to provide treatment. You have the right to inspect or copy the PHI to be used/disclosed.

* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU * *

Print Name of Patient _____

Signature of Patient _____ Date _____

Signature of Personal Representative _____

Description of Representative's Authority to Act for Patient: _____

Heart of Dixie Chiropractic

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Heart of Dixie Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided upon request with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice before signing this consent,
- The right to object to the use of my health information for treatment purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Heart of Dixie Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Heart of Dixie Chiropractic reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Heart of Dixie Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions on the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- [] Consent received by _____ on _____.
- [] Consent refused by patient, and treatment refused as permitted.
- [] Consent added to the patient's medical record on _____.

Heart of Dixie Chiropractic

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you in the reception area before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known to this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

Signature of Patient

Date

For further information regarding this notice, please contact our office at (256)837-8111

**Identification of Persons with
Authorization of Access to Patient Health Information**

I understand that, under the Federal HIPAA Law, Heart of Dixie Chiropractic cannot discuss my treatment, account balance, or any other personal matters unless I provide consent. I agree that the following individuals may be informed about my relationship with this clinic, including, but not limited to, my treatment, diagnosis, financial arrangements, account balances, appointments, and overall well-being.

Please list all individuals below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

This consent remains valid until I request in writing to delete a name or is replaced with a new form.

Signature

Date

9/8/2026