PATIENT AUTHORIZATION TO USE PROTECTED HEALTH INFORMATION

I,_____understand Arizona Sports Chiropractic and Wellness Center (hereafter referred to as "the practice") is authorized by me to use my protected health information for a purpose other than treatment, payment of healthcare operations. I have read this authorization and understand what information will be used and who may use the information. I specifically authorize any current employee or owner of the practice or any other individual listed below to use my protected health information as described below. I further understand that I retain the right to revoke this authorization, any revocations must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

DESCRIPTION OF THE INFORMATION TO BE USED (SIGN ALL THAT APPLY)

I authorize that my name will be signed on a "community" sign in sheet where others may see my name._____

I authorize that my name will be put in a schedule book upon making appointments, this book is open faced._____

I authorize that my therapy, exercises, adjustments, and discussions regarding my health and medical care, may be done in an open area of the office, which at times I understand will be in the presence of other patients. I understand that I have the right to request that these matters be performed and/or discussed in private with my health care provider, and that it is my responsibility to bring this to the attention of the doctor and staff, and make said at the beginning of or prior to my appointment, treatment or discussions.

office._____

I authorize that my information may be used to send me mail or e-mail for such items like: birthday cards, reminder cards, or promotional flyers._____

I authorize that my information may be used for the office "Thank You" board, which may consist of my name._____

I authorize any employee of the practice to call me at my residence or at work and speak with me or leave me a message regarding my treatment on any recording device, including leaving messages with family members._____

I authorize any employee of the practice to send me electronic mail when an electronic mail address is provided. Examples of things that can be e-mailed are newsletters, appointment reminders and office hour changes._____

I authorize my photograph to be taken and used within the office._____

I authorize that if I give the practice a testimonial of the care rendered to me, it may be placed in a book that other patients may read._____

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. If you would like to place any restriction on the use or disclosure of your health information, please let us know in writing.

_____ _____

PATIENT NAME PRINTED **DATE**

_____ _____

PATIENT SIGNATURE **AUTHORIZED PROVIDER REPRESENTATIVE**