BOSSIER CITY CHIROPRACTIC CENTER

PATIENT AUTHORIZATION
FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

1. I understand that this authorization is valid from date of signature for seven (7) years.
2. I understand that the purpose or use of the disclosure I am granting is necessary for the Practice to provide treatment to me and also necessary for the Practice to obtain payments for that treatment and to carry out its health care operations.
3. I expressly acknowledge that this authorization is voluntary.
4. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
6. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
7. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.
8. I understand that I may see and copy this information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
9. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
10. This authorization is valid as of ____/____/____, the date I have signed below.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Guardian, Parent if a minor) Relationship

_____

Witness