Sutphin Chiropractic Acupuncture, PLLC
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PHI Use and Disclosure – HIPAA Authorization Form

I hereby authorize Sutphin Chiropractic Acupuncture, PLLC to disclose my individually identifiable health information, including protected health information, to the individuals or entities listed:

Name ___________________________________ Relationship to Patient _________________

I authorize to the above-named entity or person to access or receive the following information about me (please check all that apply):

- ❑ Treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future appointment details
- ❑ Phone messages regarding appointments or test results
- ❑ Other ____

Sutphin Chiropractic Acupuncture, PLLC has my permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone

This authorization is effective through (check one):

- ❑ ____ /____ /____
- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's authorized personal representative

I understand each of the following with regard to this authorization:

- This authorization is voluntary and Sutphin Chiropractic Acupuncture may not condition treatment or payment on me providing this authorization.
- I may revoke this authorization to disclose information at any time by notifying Sutphin Chiropractic Acupuncture, PLLC in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Sutphin Chiropractic Acupuncture, PLLC until the termination request is received in writing and processed and that revocation may not be effective for uses and disclosures already made in reliance on this authorization.
- Information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy laws.

Authorization to Disclose:

____
Patient Name (print)

____ ___________________________
Patient Signature Date

____ ___________________________
Signature of Personal Representative Date

Relationship to Patient: ______________________