COMMUNITY CHIROPRACTIC
8110 Hwy 51 North, Suite #2
Millington, TN 38053

901-872-0760

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Please list anyone to whom the Doctor or Practice may disclose your PHI: (ex. Spouse, Primary Care Dr.)

Name of Person or Organization

Name of Person or Organization

The information covered by this authorization includes: (what can they have access to?)

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

Patient or Legally Authorized Individual Signature | Date

Print Patient's Full Name | Time

Witness Signature | Date