WALKER CHIROPRACTIC

104 Woodland Rd.
Augusta, GA 30907
706.504.3511
AugustaChiro.com

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

Patient Name: _____ **SSN:** _____

Date of Birth: _____/_____/_____ **E-mail Address:** _____

I_____, hereby authorize and request _____ ____to release my health information (PHI) to:

Walker Chiropractic
104 Woodland Rd
Augusta, GA 30907
Phone: 706-504-3511 Fax: 706-755-2978

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I understand that I am entitled to a copy of Walker Chiropractic's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website www.augustachiro.com or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

_____

Signature of Patient Date