Wagner Chiropractic

Healthcare Authorization Form

421 Cochran Road
Pittsburgh, Pennsylvania 15228
(412) 531-8701

Patient's Name_____SS#_____Date_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES WAGNER CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Wagner Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, holiday cards and information about treatment alternatives or other health related information.
- **OPEN ROOM AUTHORIZATION:** I give Dr. Wagner permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with Dr. Wagner privately, a room is provided for these conversations.
- By signing this form you are giving Wagner Chiropractic permission to use and disclose your protected health information in accordance with the above directives.

EXPIRATION

The Authorization will expire on the following date:_____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mail or hand delivering a written notice to the Privacy Official of Wagner Chiropractic. The written notice must contain the following information:

- Your name, Social Security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION.
- The date of your request
- Your Signature

The revocation is not effective until it is received by the Privacy Official.
This Authorization is requested by Wagner Chiropractic for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*
You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Wagner Chiropractic will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A copy of the signed authorization will be provided to you

Print Name of PATIENT_____

Signature of PATIENT_____DATE_____

Signature of Personal Representative_____

Description of Representative's Authority to act for patient_____