ZAK CHIROPRACTIC, LLC
208 SE 3rd Street, Lees Summit MO 64063
Phone (816) 525-9900 Fax (816) 525-9578

HEALTHCARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of this notice is attached and I have been encouraged to read it and request a copy if I would like one.

This Notice of Privacy Practices also describes my rights and the duties of the Chiropractor with respect to my protected health information. I hereby give permission to Zak Chiropractic, LLC to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- To use my address, phone number, email address, and clinical records to contact me with appointment reminders, missed appointment notification, billing/collection efforts, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- To send a thank you letter including my name to the person referring me to their office.
- To leave a phone message on my answering machine or voice mail.
- To use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- To use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- To provide chiropractic care in an "open-door" adjusting environment. 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 the doctor at any time in private, I will notify the doctor or his staff and they will do their best to accommodate my wishes.

By signing this form I am giving Zak Chiropractic, LLC permission to use and disclose my protected health information in accordance with the directives listed above. Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill in the ones you agree to)

Phone _____ Email _____ Text _____

The use of this format is intended to make my experience with this office more efficient and productive as well as to enhance my access to quality health care and health information. This authorization will remain in effect for the duration of my care at Zak Chiropractic, LLC plus 7 years or until revoked by me.

(over)

RIGHT TO REVOKE AUTHORIZATION:
I have the right to revoke this AUTHORIZATION, in writing, at any time. However, my written request to revoke this AUTHORIZATION is not effective to the extent that Zak Chiropractic, LLC has provided services or taken action in reliance on my authorization.

I may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Zak Chiropractic, LLC. The written notice must contain the following information:

My name, address, and date of birth;
A clear statement of my intent to revoke this AUTHORIZATION;
The date of my request; and
My signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Zak Chiropractic, LLC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Zak Chiropractic, LLC will not refuse to provide treatment however, it will not be possible for Zak Chiropractic to file third party billing on my behalf (if applicable) and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Zak Chiropractic, LLC will be unable to contact me 3) all contact with Zak Chiropractic, LLC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Patient Authorization to Release Health Information and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

For minors or patients being represented by another party:

Personal Representative Name (printed): _____

Personal Representative Signature: _____

Date: _____

Description of Representative's Authority to Act on Patient's Behalf: _____

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