

**HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION**

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that with your specific permission, Active Family Chiropractic may use your picture or a personally written testimonial regarding your experience here for the purpose(s) of display, advertising or other undisclosed uses. We may also use your personal information (name, address and phone numbers) to leave messages on your voice mail or answering machine and send you promotional materials from our office. By signing this you also acknowledge that all adjusting is done in an open setting where incidental disclosures of personal information may happen. Private consultations are available on request.

By signing this authorization you agree that Active Family Chiropractic or its Business Associates may disclose your personal health care information to our business associates for purposes of treatment by other professionals or for payment and billing related inquires.

While Active Family Chiropractic has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Active Family Chiropractic at any of its offices or by sending a written request with return address to Active Family Chiropractic 3390 C-Annapolis Lane N, Plymouth, MN 55447

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your Personal Health Information in the designated record set maintained by Active Family Chiropractic as long as the personal health information is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Active Family Chiropractic has taken action in reliance on it. A revocation is effective upon receipt by Active Family Chiropractic of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall remain in effect as long as your patient file is maintained by Active Family Chiropractic.

By signing this authorization you acknowledge and agree that nay information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Active Family Chiropractic will provide you with a copy of this signed authorization.

Acknowledged and agreed to by:

Patient: _____ Date: _____