Lorraine Parker Chiropractic

LORRAINE PARKER, D.C.
Chiropractor

HIPPA 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)

The Health Insurance Portability and Accountability Act of 1996 require that we protect the privacy of your protected health information. You have a right to request a copy of your protected health information contained in a designated record set and help by **Dr. PARKER** This request must be made in writing. The department will act on your request within 30 days unless we provide you with notification in writing than an extension of up to 30 days is needed.

This Notice of Privacy practices describes how we may use and disclose your protected health information to carry out treatment payment or health care operations and for other purposes that are permitted or required by law. Protected healthy information is information about you, including demographic information, that may identify you and that relates to your past present or future physical or mental health condition and related health care services.

1. I authorize Dr. Parker to use and disclose the protected health information described below for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

2. I authorize Dr. Parker to use and disclose the protected health information to provide, coordinate, or manage my health care and any related services. this includes the coordination or management with a third party. (For example, home health agency, physician to whom you have been referred to)

3. I authorize Dr. Parker to use and disclose the protected health information in order to support the business activities of my physician's practice. They may also call me by my name in the waiting room when Dr. Parker is ready to see me. They may use or disclose my protected health information, as necessary, to contact me to remind me of my appointment.

4. I understand that I have the right to request a written copy of my records from Dr. Parker according to policy procedure. My signature is required to release my records to me or another party as I have specified. The department has up to 38 days to process this request. By signing below, I am authorizing a copy of my records to be mailed, faxed, or emailed as requested. I understand that I must request a copy of my records in order for them to be sent.

5. 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.

6. I authorize Dr. Parker to use and disclose the protected health insurance information described below to (_____) (spouse, relative), if other than me.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases; health oversight abuse or neglect Food and Drug Administration requirements, legal proceedings, law enforcement coroners, funeral directors, and organ donation.

SIGNATURE BELOW IS AN ACKNOWLEDGMENT THAT YOU HAVE RECEIVED, READ, AND UNDERSTAND THIS NOTICE OF OUR PRIVACY PRACTICES.

SIGNATURE: _____ DATE: _____

EMAIL: _____