Arizona Chiropractic Center
7717 West Deer Valley Road
Suite 135
Peoria, AZ 85382
623.512.4040

Patient's Privacy Authorization Form

To Dr. Christopher J. Koch
Privacy Director – Arizona Chiropractic Center:

This form is required by the Health Insurance Portability and Accountability Act of 1996 in compliance with the privacy regulation effective for this office on April 14, 2003, **only if our office wishes to use or disclose your protected health information for any other purpose not clearly spelled out in our office Privacy Policy Notice.**

To use or disclose your protected health information in such cases, our office must receive prior written authorization from you, the patient. Our office may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. The purpose for which our office is requesting your authorization is as follows:

- The information to be disclosed would be limited to use of name, photographic image, written testimonial of results received in office which is provided by patient, and other internal and external promotions that ACC utilizes.
- Dates for which authorization would be valid: From date of consultation to indefinite.

By agreeing to this authorization, you understand that the potential for information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient only upon pre-authorization by patient and will be protected by the privacy regulation of HIPAA. You also understand that you are entitled to receive a copy of this authorization form.

If you agree to these terms, sign below:

I, _____ acknowledge that I received and reviewed the office Privacy Policy Notice for Arizona Chiropractic Center and also give my authorization to Arizona Chiropractic Center for the purpose stated above. I understand that I can revoke this authorization at any point in the future by submitting written notice to Arizona Chiropractic Center.

We will contact you by email with health & wellness related information unless otherwise specified, in writing, by you, the patient. We will NEVER share your email address with anyone.

_____
Printed Name / Date

These medical records may be released to:

_____ 1st, 2nd, or 3rd party insurance representatives
_____ Your Attorney
_____ Yourself
_____ Relative _____
_____ Other _____

PLEASE NOTE:

In case you do not agree to sign this form, our office must indicate why you declined to do so.
Reason for patient's refusal:

_____
Printed Name / Date