REGIONAL CHIROPRACTIC CENTER
LAKE NORMAN
736 Brawley School Road • Suite E • Mooresville, NC 28117
Office: 704-664-1031 • Fax: 704-664-1035 • www.regionalcc.com

HEALTH CARE AUTHORIZATION FORM

THE PATIENT IDENTIFIED BELOW AUTHORIZES REGIONAL CHIROPRACTIC CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

Regional Chiropractic Center may use your health information to provide or coordinate your medical treatment and services. We may also provide that information to other healthcare providers who may assist in your treatment.
Regional Chiropractic Center may use and disclose your health information so that the services you receive in this office may be billed and/or collected from you, an insurance company, or third party. We may need to share information with your insurer so as to receive proper reimbursement and/or obtain prior approval for treatment and services. We may also use and disclose health information to third parties that may be responsible for costs and expenses such as family members.

SPECIFIC AUTHORIZATIONS

I give permission to Regional Chiropractic Center to use my phone number or address to contact you to confirm an upcoming appointment. *Please contact us if you do not want to be notified.*
I give permission to Regional Chiropractic Center to use my address and/or phone number to contact you with birthday cards, holiday related cards, sympathy cards, thank you cards, and information about health alternatives or other health related information.
I give Regional Chiropractic Center permission that any pictures that are sent to the office of non-medial purposes can be posted in the office. (Holiday cards, birth announcements)
I give permission to Regional Chiropractic Center to disclose health information to a family member or friend who assists in care giving and/or accompanies a child to the office such as stepparent, nanny, grandparent, etc. *Please note any unauthorized persons.*
Other uses and disclose of protected health information for any purpose other than those indentified in this notice can be made with your written authorization or that of a legal guardian. At any time, you or your legal guardian may revoke the authorization in writing. We will no longer release information upon receipt of the notice but cannot take back disclosures already made with your permission.
By signing this form you are giving Regional Chiropractic Center permission to use and disclose your protected health information in accordance with the directives listed above.

Print Name of Patient: _____

Signature of Patient: _____ Date: _____

Doctors Signature: _____ Date: _____

Please list on the following lines, persons that have your permission to have access to your health records:

1._____ 2._____

I have received a copy of the Notice of Privacy Practices _____
Signature