CHIROPRACTIC CENTER OF MYRTLE BEACH
3500 N. Kings Hwy
Myrtle Beach, SC 29577
(843) 448-7656

PATIENT DISCLOSURE AUTHORIZATION (Patient Privacy Act)

Patient Legal Name: _______________________________________ Account Number: ________________________

Please read each statement below. Put YOUR INITIALS beside the ones that you agree to.

I hereby authorize this office to:

_____ Contact me at home.
_____ Leave message on home answering machine.
_____ Leave message at home with person that answers call.

_____ Contact me at my workplace.
_____ Leave message on my workplace voice mail.
_____ Leave message at my workplace with a co-worker, manager, etc.

_____ Contact me by cell phone. (Be advised that cell phones are ***NOT*** secure lines and your conversation may be overheard.)
_____ Leave me a message on my cell phone voice mail.
_____ Text message me on my cell phone.

_____ E-mail me. Please write your e-mail address here: ____
_____ Send mail containing information protected by this document to my home or post office box via the United States Postal Service.

_____ Allow my spouse / family member to accompany me to treatment area during treatment.

X____ ______________________
Patient or Authorized Representative Signature Date

____ ______________________
Authorized Signature of Facility Date

**** I hereby authorize this office to use or disclose my Patient Health Information to the following person(s) (spouse, parents, relatives, friends) or entity(s). **Please LIST NAMES** (if you do not want to list anyone, please write **"NONE"**):

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** I understand that the information disclosed may be re-disclosed to additional parties and no longer protected for reasons beyond office control.

** I understand I have the right to:

1) Revoke this authorization at any time, by making a request in writing, except for information already used or disclosed.
2) Refuse to sign this authorization. By refusing to sign, no one (even though listed above) may have access to my information with the exception of
a court order. Initial here if refusing to sign: __________
3) Receive a copy of this completed and signed authorization.

I also understand that this practice will not condition my treatment upon my refusal to sign this authorization to disclose my protected health information.

X____ ______________________
Patient or Authorized Representative Signature Date

____ ______________________
Authorized Signature of Facility Date