CAROLINA
Active Health
CHIROPRACTIC

Authorization of Private Health Information

Privacy Practices Acknowledgement

Authorization to discuss PHI (Private Health Information)

I (print name) _____ authorize *Carolina Active Health Chiropractic Inc.*, to use or disclose the specific information described below, only for the purpose and parties also described below.

Description of Specific Information to be discussed:

○ Appointment Dates/ Times ○ Diagnosis ○ X- Ray / Lab Results ○ Medications ○ Care Plan

○ Summary of Medical Record ○ Other as specified:

Name of Individual:	Relationship:	Contact Number:

As part of our holistic approach, Carolina Active Health would like to communicate and/or share our clinical findings, treatment plans and therapeutic outcomes with your Primary Care Doctor. If you would like to consent to this process, please complete the following information:

_____ _____

Name of Primary Care Dr and/or Practice Name Phone Number

_____

Address

This authorization shall remain in effect from the date signed below and until _____ or 365 days have lapsed.

By signing below you authorize and understand this form is as described;

- This form is legally binding.
- You may inspect or copy the protected health information to be used or disclosed.
- You may revoke, add, or change, at any time, in writing this authorization by contacting *Carolina Active Health Chiropractic Inc.*, office at 864-881-2242.
- This authorization is giving *Carolina Active Health Chiropractic Inc*., the right to disclose and or discuss my medical information as specified with the **individuals listed above.**
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

Patient Acknowledgment of Privacy Practices

I have received and/or reviewed the Notice of Privacy Practice for *Carolina Active Health Chiropractic Inc.*, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agree to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.
I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient name: (Print) _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship of authority if not signed by the patient: _____

Witness name: _____