Shoar
Chiropractic & Acupuncture

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name: _____ Date of Birth: _____

I authorize (healthcare provider) _____to disclose and furnish the protected health information described to **Shoar Chiropractic, Inc.**, A California Health Providers Group.
Fax Number: **805-278-9047** Office Address: **1603 E. Gonzalez Rd., Oxnard, CA 93031**

Effective Period

This authorization for release of information covers the period of healthcare

from: ☐ a. _____to _____

OR

☐ b. all past, present, and future periods.

Extent of Authorization

☐ a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ b. I authorize the release of my complete health record with the **exception** of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until _____(date or event), at which time this authorization expires.

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.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed name of patient _____ _____
(or personal representative) (relationship to patient)

Signature of patientorpersonalrepresentative:_____ Date _____