Heppner Chiropractic
925 Commercial St. SE Suite #260
P.O. Box 4653
Salem, OR 97302
(503) 391-9222

Patient Authorization for Disclosure of Protected Health Information.

The Health Insurance Portability and Accountability Act of 1996 enforces how the Protected Health Information of our patients can be disclosed. This form authorizes the staff at **Heppner Chiropractic** to discuss your Protected Health Information in the manner that you choose.

Patient Name _____Date of birth_____

Patient Signature_____
Date_____

_____ (Initial) **Notice of Privacy Practices / HIPAA:** I acknowledge that a copy of this office's Notice of Privacy Practices has been made available for me to read and keep, if desired.

I would prefer not to share any of my personal health information.

Individuals to whom you wish your information be disclosed (check all that apply)

Spouse, Name
_____

Parent / Child, Name(s)
_____

Other, (i.e. Primary Care Physician, Attorney, Other)
_____

Can a detailed message be left on your answering machine?

No
Yes, best phone number _____ **What information can be shared? (check all that apply)**

- € All information at the doctors' discretion
- € Appointment info: Time, date and provider's name
- € Billing/Insurance information
- € Medical information and diagnosis
- € Radiology results / lab test results
- € Only return a call message
- € Other_____
- € Exclude specifically_____

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I authorize the information below to be used, disclosed, or released as part of my record, if such information exists;

_____HIV/AIDS*
_____Alcohol/drug abuse*
_____Genetic testing*
_____Mental Health*
Must be initialed to be included with other documents

The patient has the right to revoke this authorization in writing. This authorization will remain in effect unless otherwise revoked by the patient. Release of the PHI covered by this authorization will be disclosed solely for the purpose of keeping selected people informed of your healthcare condition.