Authorization for Healthcare Information

Patient's Name:_____ Date of Birth:_____

Previous Name/Alias:_____ SSN:_____

I request and authorize KJG, LLC dba FAMILY LIFE CHIROPRACTIC to release healthcare information of the patient named above to the following people:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

□ YES □ NO I authorize the release of my healthcare records in their entirety to the person(s) listed above. This includes: Appointments, treatments, and health conditions.

□ YES □ NO I authorize the release of any records regarding any financials, including insurance, payments, and/or account billing to person(s) listed above

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I also understand that this facility has the right to change its Notice of Privacy Practices and that I may contact the facility at any time to obtain a current copy of the Notice of Privacy Practices.

By signing this Agreement, ***you are only acknowledging that you have received or been given the opportunity to receive a copy*** *of our Notice of Privacy Practices.*

Patient Name (Print):_____ Date:_____

Patient/Guardian Signature:_____

□***By checking this box, I do not agree to the terms included under the Notice of Privacy Practices and decline to sign the agreement.***

OFFICE USE ONLY: We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices

Date:_____ Patient Attempted:_____

Staff Name:_____

Staff Signature:_____