Jones Chiropractic & Physical Therapy, LTD.

719 & 721 S. Washington Bunker Hill, IL 62014

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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)**

1. Authorization

I authorize **JONES CHIROPRACTIC AND PHYSICAL THERAPY, LTD.,** (healthcare provider) to use and disclose the protected health information to requested parties as listed below :

☐ Referring Physician ☐ Insurance ☐ Attorney

And / or persons involved in my care including:

Name	Relationship

I do not wish to have my health information disclosed to individuals involved in my care.

Name	Relationship

2. Effective Period

This authorization for release of information expires one year from date of signature with the exception of Automobile or/and Workers Compensation claims that will expire upon settlement of claim.

3. Extent of Authorization

a. I authorize the release of my complete health record with the exception of the following information:
(check the below boxes to not send)

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

4. Request and Release

a. This medical information may be used by the clinic as authorized to request or release this information for medical treatment or consultation, billing and claims payment, or other purposes as I may direct.

b. 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.

c. 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.

5. Financial Obligation

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

b. I understand that I am responsible for any co-payments at time of service, and any amounts as not covered by my insurance.

c. I understand that if my insurance carrier denies any or part of my claim, or if I and my physician elect to continue therapy past my approved period, I will be responsible for my account balance in full. For your convenience we accept cash, checks and most major credit cards.

8. I authorize my records to be released, as requested, by:

☐ Mail ☐ Fax ☐ Email ☐ Hand Delivery ☐ **All of the above**

9. I authorize contact from this office to confirm my appointments, treatments & billing information as well as information about my health to be conveyed via:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text Message to my Cell Phone ☐ Email ☐ **Any of the above**

I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

I have furnished the condition of my health to the best of my knowledge to the providers and consent to treatment at this clinic as considered necessary and proper in diagnosing or treating my/his/her (minor or legal guardianship) of physical condition.

____ Date:________________

Signature of patient or personal representative

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Printed name of patient or legal representative and his/ her relationship to patient