HEALTH CARE AUTHORIZATION FORM

Patient's Name_____

Patient's SS #_____ Date of Birth_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ZIMMERMAN FAMILY WELLNESS TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

___• I give permission to Zimmerman Family Wellness to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information. Patients in our practice may be contacted via text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information**.**

I consent to receiving appointment reminders and other healthcare communications/information via text from Zimmerman Family Wellness and Neuropathy.

_____ (**Patient initials**) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The **cell phone number** I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is:

(_____)_____

___• If Zimmerman Family Wellness contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

___• I give Zimmerman Family Wellness permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

___• By signing this form you are giving Zimmerman Family Wellness permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the privacy official of Zimmerman Chiropractic. The written notice must contain the following information:

Your name, social security number, and date of birth. A clear statement of your intent to revoke this AUTHORIZATION; The date of your request and Your signature.

The revocation is not effective until it is received by the privacy official.

Zimmerman Chiropractic requests this AUTHORIZATION for its own use/disclosure of PHI (minimum necessary standards apply).

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Zimmerman Chiropractic will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

_____

Printed Name of Patient

_____

Signature of Patient

_____

Signature of Personal Representative

_____

Description of Representative's Authority to Act for Patient