MILLENNIUM CHIROPRACTIC & REHAB

The privacy law, Health Insurance Portability & Accountability (HIPPA), protects your individually identifiable health information (protected health information). The privacy law requires you to sign an authorization (or agreement) in order for your healthcare provider to request or disclose your protected health information.

By signing this form you are giving us authorization to send the Millennium Chiropractic & Rehab/ Northwest Arkansas Digital Motion X-Ray this information. You are also giving the Millennium Chiropractic & Rehab/ Northwest Arkansas Digital Motion X-Ray authorization to re-disclose your information to the party responsible for the payment of your services, the Millennium Chiropractic & Rehab/ Northwest Arkansas Digital Motion X-Ray legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You have the right to request and obtain a copy of your health records at any time.

You may inspect or copy the information that we may send to the Millennium Chiropractic & Rehab/ Northwest Arkansas Digital Motion X-Ray at any time. (164.524)

This notice is effective as of today's date (below). This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Representative
_____	_____
Personal Representative Printed	Personal Representative Signature

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PRIVACY PRACTICES ACKOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review.

Name: _____ Birth date: _____

Signature: _____ Date: _____