

HIPAA Policy Required Authorizations

Patient Name: _____ Date of Birth: _____ M or F

Patient's Mailing Address: _____ City _____ St./zip _____

Social Security Number: _____

I authorize the release, disclosure and use of health information obtained on the above individual for the purpose of continuing care and treatment by:

Lonny R. McKinzie, D.C.
3325 Chandler Hwy, Tyler, TX. 75702
Phone: 903-531-2243, fax: 903-531-2248.

This information is to include:

- ___ most recent date of treatment,
- ___ most recent discharge summary or for dates _____,
- ___ most recent history and physical or dates _____,
- ___ most recent Operative Report or dates _____,
- ___ lab results,
- ___ pathology reports,
- ___ radiology and imaging reports or dates _____,
- ___ other tests (specify) _____,
- ___ Entire Medical Records for dates _____,
- ___ pictures.

I understand that the information used or disclosed pursuant to this authorization form may include information relating to HIV or AIDS; treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand the authorization is valid indefinitely unless otherwise stated. I understand that I may revoke this authorization at any time and that if I revoke this authorization, I must do so in writing to Dr. McKinzie at the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization.

You have the right to withdraw authorization in writing at any time.

I have read and understand the above stated authorizations and agree to those that have been checked.

X _____
Signature of Patient or Qualified Personal Representative

Printed Name

Authority to act on behalf of patient (Parent/Guardian, executor, etc.)

Signature of Witness

Printed Name of Witness

Date

PLEASE INITIAL EACH ONE YOU GIVE US PERMISSION TO USE:

_____ I give my permission for Lonny R. McKinzie, D.C. and McKinzie Wellness Center to send me via mail or e-mail the following:

- A. Birthday or Christmas cards, Thank you cards, or notices of special events or a Patient Appreciation Day. In these cards we may offer you a discounted service or product.
- B. Patient's newsletters about our office, upcoming products and services or general information.

_____ We may use your name on a "Thank You" referral board in the waiting area or in printed material.

_____ We have your permission to use your child's (first) name, picture or drawing in our office or in printed material.

Address to use for mail (if different from above): _____

Email address: _____

This is to inform you that we also may call you to remind you of appointments or to check to see how you are feeling after treatment.

We may need to send through mail or e-mail reminders of appointments, missed appointments, or the need for additional information.

If you wish to change the address or phone number where you can be reached, you may do so in writing, by calling the office or request an update form from the office.

Please be aware that we have an open office adjusting setting. If you have a private matter you need to discuss regarding payment or treatment, please inform the front desk or the doctor in order to make arrangements for a more secure area to discuss private matters. For your protection, our employees or business associates must sign a confidentiality agreement regarding our office procedures and the use of your private health information. Staff only has rights to your information needed to perform their job duties. An example of a business associate can be anyone who we contract out to do transcriptions, record copying, a management company, or collection agencies. We have implemented agreements, policies and procedure to assure the protection of your privacy.

IMPORTANT: If you wish to allow a spouse or family member access to health information you must sign to give permission. Only those listed below will have access to your records.

"I give the following person or person's permission to access my health information:

(Names of those who have access to your records) _____

I have read and understand the above stated authorizations and agree to those that I have initialed.

X _____
Signature

Printed Name

Date