

HIPPA Privacy Rule of Patient Authorization Agreement

Dr. Robert Vallandingham, DC

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my health care, Dr. Robert Vallandingham DC, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

If requested, I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Dr. Robert Vallandingham DC, notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Dr. Robert Vallandingham DC Notice of Information practices prior to signing this consent;
- That Dr. Robert Vallandingham DC, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Robert Vallandingham DC, is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent Dr. Robert Vallandingham DC, has already taken action in reliance thereon.

Signature of Patient or
Guardian.....

Printed Name of Patient
.....

Date:

**a printed copy of the Notice of Privacy Practices is given upon request*