
Rugani Family Chiropractic, P.C.
1733 Route 9 Clifton Park, NY 12065 PH: (518) 348-6366

Authorization to Use and Disclose Health Information

1. INDIVIDUAL PATIENT

I give my authorization to use or disclose my protected health information as described in section 2 below.

Your Name: _____ Social Security Number _____

Legal Responsibility

- If you are 18 years old or older, you are legally responsible for yourself, check this box.
- If you are an emancipated child or teenager and your parents no longer have custody over you, check here.
- If you are a child or teenager and your parents are divorced, please check this box. Below please list the name of the parent or guardian who has custody over you.

2. THE USE AND / OR DISCLOSURE

A. I understand that under the HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse who is involved with your insurance claims fulfillment.

B. Under these new regulations the following people must be authorized by you to have access to your health information: your spouse, other family members, and friends; nurse or home aid; legal guardian; or other person/organization who is not involved with your medical treatment, insurance plan, or payment.

Below Please list the people /organizations that you authorize to have access to your information:
Persons/Organizations Receiving the Information:

- 1) Name _____ Contact Phone: _____
Address: _____ Relationship to the Patient: _____
What Specific Information to Disclose _____
When Date Will the Disclosure Expire _____
- 2) Name _____ Contact Phone: _____
Address: _____ Relationship to the Patient: _____
What Specific Information to Disclose _____
When Date Will the Disclosure Expire _____

3. CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer.

4. METHOD OF CONTACT

I authorize the office of Rugani Family Chiropractic, P.C. to contact me in the following manner:

- | | |
|---|--|
| ___ Home Telephone _____ | Written Mail |
| ___ OK to leave message with detailed information | ___ OK to mail to my home address |
| ___ Leave message with a call back number only | ___ OK to mail to my work/office address |
| | ___ Ok to fax to this number _____ |
| ___ Work Telephone Number _____ | |
| ___ OK to leave message with detailed information | |
| ___ Leave message with a call back number only | |

5. STATEMENT OF UNDERSTANDING

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates of Rugani Family Chiropractic, P.C. who are part of the health care process. These business associates will also keep your health information confidential.

By: _____
(Patient)

Date: _____

Or By: _____
(Patient's Representative)

Date: _____

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Description of Representative's Authority _____

NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Dr. Silvio T Rugani (518) 348-6366

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Signature of Patient or Legal Representative

Witness

Date

Date