Sadon Chiropractic & Rehabilitation Center, PC
186 County Road 520, Suite 1
Marlboro, NJ 07751

HIPAA AUTHORIZATION

For use or disclosure of health care information

By signing this form I, _____, authorize the use and disclosure of my health information as described below.

How We May Use and Disclose Medical Information About You

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other- doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile. We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third-party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services, we recommend for you.

For Healthcare Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conduction or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include collections and software support. If their services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract. In addition, business associates are individually required to abide by the HIPPA rules.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

ACKNOLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You May Refuse to Sign This Acknowledgement*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

****FOR OFFICE USE ONLY****

Acknowledgement could not be obtained because:

____ Patient refused to sign

____ Communication barriers prohibited obtaining acknowledgement

____ An emergency situation prevented obtaining acknowledgement

____ Other (Please Specify) _____