ASSIGNMENT & RELEASE

I Authorize release of information to family physicians and employer. I authorize release of information to insurance companies. I authorize the taking of photographs and x-rays to be used for treatment purposes . I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes. I authorize my insurance benefits to be paid directly to:

METRO CHIROPRACTIC CENTER
DR. KRISTINE B. SIMONSON
701 N. 132ND STREET
OMAHA, NE 68154

I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services will be IMMEDIATELY due and payable.

PATIENT'S
SIGNATURE:_____DATE:_____

GUARDIAN'S
SIGNATURE_____DATE:_____

HIPAAPATIENT AUTHORIZATION FORM
METRO CHIROPRACTIC P.C.

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your Protected Health Information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from _____,20_____ to _____,20_____

By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software provider Infinedi of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.

The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We WILL NOT ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by: _____
Printed Name- Patient or Representative

_____
Signature Date

Relationship to patient
(if other than patient) _____

Witness _____
Printed Name- Clinic Representative

_____
Signature Date

For Internal Use

☐ Patient Refused to Sign ☐ Patient unable to sign for the following reason: _____