Christina Kulesz, D.C.
HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____

Patient's SS#: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES Christina Kulesz, D.C. TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING: **(please initial specific authorizations)**

_____ I give permission to Christina Kulesz, D.C. to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

_____ If Christina Kulesz, D.C. contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

I give Christina Kulesz, D.C. permission to disclose information about my appointments and financial balance(s) to the following person(s) until I revoke said permissions in writing:

_____ Name(s) _____

_____

_____

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. A RIGHT TO REVOKE form will be provided upon request. You MUST give this written notice to the Privacy Official of The Office of Christina C. Kulesz D.C.. The written notice must contain the following information:
Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and your signature.

The revocation is not effective until it is received by the Privacy Official of Christina C. Kulesz D.C.

This AUTHORIZATION is requested by Chirstina Kulesz, D.C. for its own use/disclosure of PHI.
(Minimum necessary standards apply.)
You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Christina C. Kulesz, D.C. will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

_____ _____ _____
PRINT NAME OF PATIENT SIGNATURE OF PATIENT DATE

If you have a personal representative, please provide their name, signature and a description of your representative's authority to act for you (the patient) below or on the back of this form.