West University Wellness, P.C.
Health Care Authorization Form

Patient's Name: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **West University Wellness** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

Open Room Authorization

_____ (Initial) I give **West University Wellness** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of my care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

Authorization of Treatment

_____ (Initial) I hereby authorize **West University Wellness** to treat my condition, as they deem appropriate through the use of chiropractic manipulation, physical modalities and/or acupuncture. **West University Wellness**, including its doctors and staff, will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I agree that I am ultimately responsible for all bills incurred by me at this office.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ (Initial) I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Patient/Guardian Signature Date