# Join ChiroVoice and Support Chiropractic

Unite with patients across the country to protect your access to essential health care services provided by doctors of chiropractic. Together, we can educate policymakers about the value of chiropractic.

There is a no cost sign up and as a participant you will receive legislative updates and a monthly e-newsletter containing health information and tips on how best to correspond with your elected officials.

Name _____

Email _____

Address _____

City _____ State_____ Zip_____

Phone (optional) _____

Doctor of Chiropractic _____

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**Patient Authorization to Use and Disclose Protected Health Information (PHI)**

- Because this form when completed may contain the name of the patient's doctor, it may be Protected Health Information under HIPAA. Therefore if the Doctor assists the patient with completing and sending this form to ChiroVoice, HIPAA requires that the patient sign this Authorization and that a copy be retained in the patient record. The patient may also go directly to the ChiroVoice web page and sign up on line, in which case an authorization for release is not required.

I hereby authorize the above-named Practice (the "Practice") to use and disclose the following Protected Health Information ("PHI") on this form: Patient name, email address, mailing address, telephone number, and name of doctor of chiropractic.
The above-described PHI will be released to the American Chiropractic Association ("ACA").
The ACA may use this PHI for the following purposes: to send you information about new developments in chiropractic and related health care issues, including monthly electronic newsletters and email alert bulletins regarding health care reform issues from the American Chiropractic Association with links to allow you to contact your legislators regarding important chiropractic issues.

I understand and acknowledge that:

1. The Practice will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
2. This Authorization is voluntary and I may refuse to agree to its terms without affecting any of my rights to receive health care at the Practice.
3. This Authorization may be revoked at any time by notifying the Practice in writing to the attention "Privacy Officer."
4. The recovation of this Authorization will not have any effect on disclosures occuring prior to the execution of any revocation.
5. The information used or disclosed pursuant to this Authorization may be subject to being disclosed again by the recipient, the ACA, and thus this information will no longer be protected by federal privacy regulations.
6. My health care and payment for my healthcare will not be affected if I do not sign this form.
7. I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
8. This form was completely filled in before I signed it and I knowledge that all of my questions were answered to my satisfaction, that I fully understand this Authorization form, and have received an executed copy.
9. This Authorization is valid as of the date I have signed below and shall remain valid for a period of one year.

_____ _____

Name of Individual (Printed) Signature of Individual Date