Boas Family Chiropractic
479 Rt. 79, Suite #15
Morganville, NJ 07757
Tel: (732) 591-2580 Fax: (732) 591-1525

AUTHORIZATION FOR APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION

There must be times when the doctor or members of the doctor's team, may need to use your private health information such as your name, address, phone number or clinical records in order to contact you in regard to:

- Appointment Reminders
- Information about alternative treatment
- Or other health related information that may be of interest to you

If you are not at home to receive an appointment reminder, a message could be left on your answering machine. By signing the form, you are giving us authorization to contact you with these reminders and/or information.

Your Rights

You may restrict the individuals or organizations to which PHI is released, or you may revoke your authorization to us at any time with the following rules:

Your revocations must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your private health insurance information before we received your request to revoke authorization. If you were required to give your authorization as a condition of obtaining Insurance, the Insurance company may have the right to your private health information should they decide to contest any of your claims.

Information that we use to disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for services rendered to you.

You have the right to inspect or copy the information that we use to contact you for appointment reminders, information about treatment alternatives or other health related information at any time.

This notice is effective as of _____.
This notice will expire seven years after the date upon which the record was created.
I have read your authorization and agree to its terms.
My signature authorizes you to disclose my private health information in the manner described above.

_____	_____
Printed Patient Name	Printed Authorization Provider Name
_____	_____
Patient Signature	Signature of Authorized Provider Name
_____	
Today's Date	