ChiroHealthUSA
The Network That Works for Chiropractic!

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR ENROLLMENT AND MEMBERSHIP IN THE CHIROHEALTHUSA NETWORK

I, , authorize my provider,_____, to use and disclose my health information (including my name, phone number, address, email address, date of birth, gender, dependents name, name of my provider, and payment information) to ChiroHealthUSA for purposes of enrolling me in the ChiroHealthUSA network, and to send me marketing materials and other communications related to my ChiroHealthUSA network membership. I understand that my provider will not receive direct or indirect remuneration from ChiroHealthUSA in connection with this use and disclosure of my health information.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") and various state laws govern the terms of this Authorization. I understand this Authorization is limited to only the health information described above, and does not apply to sensitive categories of information (such as psychotherapy notes, genetic, mental health, substance abuse, or HIV/AIDS information).

I understand that I may revoke this Authorization at any time by contacting my provider and/or ChiroHealthUSA in writing at 1307 Airport Rd. N., Suite 1A, Flowood, MS 39232, 888-719-9990. My revocation will be effective upon my provider and/or ChiroHealthUSA's receipt of such revocation, but will not be effective to the extent that they have already acted in reliance upon my prior Authorization.

I understand that my provider may not condition treatment or payment, or eligibility for benefits or enrollment in a health plan, on my signing of this Authorization. I understand that my health information disclosed pursuant to this Authorization may be further used and disclosed by ChiroHealthUSA to communicate with me regarding my ChiroHealthUSA membership, and no longer protected by HIPAA. I understand that I have a right to receive a copy of this Authorization.

This Authorization shall expire in accordance with the below, unless earlier revoked by me by notifying my provider and/or ChiroHealthUSA using the contact information and in the manner described above (check the applicable box):

- ☐ **Maryland**: One year from the date of signing this authorization
- ☐ **Maine**: 30 months from the date of signing this authorization
- ☐ **California**: On the_____day of_____, _____
- ☐ **All other states**: When my membership expires

_____ _____
Signature of Patient or Personal Representative Date of Signature

_____ _____
Relationship to Patient Patient Address