SOUTH CAROLINA CHIROPRACTIC ASSOCIATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the South Carolina Chiropractic Association (SCCA). This disclosure will be made if we need the SCCA's assistance to receive reimbursement for your services or, we need the SCCA's Assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are gibing us authorization to send the SCCA this information. You are also giving the SCCA authorization to re-disclose your information to the party responsible for the payment of your services, the SCCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if you have already released your health information before we receive your request to revoke your authorization.

You have the right to refuse to give us this authorization. I f 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 your care.

You may inspect or copy the information that we may send to the SCCA at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

Description of personal representative's authority to act for the patient.

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