BIONIC Chiropractic
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Authorization For Use Or Disclosure of Protected Health Information

Patient/Client Name:_____
Address:_____
SSN:_____ Date of Birth:_____

Person/Organization Releasing Information:_____
Person/Organization Receiving Information:_____

Check all that apply:
____History and Physical Exam ____Operative Reports ____Discharge Summary ____Pathology Reports
____Consultation Reports ____EKG Reports ____Laboratory Reports ____X-Ray Reports
____Emergency Room Record ____EEG Reports ____Face Sheet ____PT/OT Notes
____Other (specify):_____

For dates of treatment:_____
The purpose of the release of this information is:_____

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information (i.e. records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions). I understand that I may revoke this authorization at any time by notifying the person/organization releasing this information in writing. However, if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the person /organization receiving this information will not condition my treatment on whether I provide this authorization unless I am receiving research-related treatment or the only reason the facility is providing me with health care is to make a report to a third party. I understand that if the person/organization authorized to receive this information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.
Expiration: This authorization will expire once purpose stated above is served.

The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the office's Notice of Privacy Practices.

_____ _____
Signature of patient/client or personal representative Date

_____ _____
Printed name of personal representative (if applicable) Relationship to patient/client
Note: This authorization was revoked on:_____ (see attached revocation)

[Recipient Information: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR) 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.]

HIPAA Compliant **A Photocopy Of This Authorization Is As Valid As The Original**