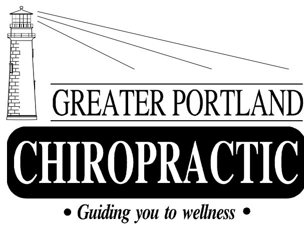

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PATIENT AUTHORIZATION FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ___________________________ hereby authorize Greater Portland Chiropractic (the Practice") to use and/or disclose to

Name of Person/Agency: ____

Address: ____

Phone Number: ____

Fax Number: ____

the following specific protected health information (check all that apply):

_____ Medical Records
_____ X-Rays
_____ Insurance Information
_____ Complete Copy of Medical File
_____ Other: ____

2. I understand that this authorization is valid for one year from signing date.

3. I understand that the purpose or use of the disclosure I am granting is:

4. I expressly acknowledge that this authorization is voluntary.

5. The following is/are other criteria or limitations that I make regarding this authorization (please note any limitations):

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that this authorization may be revoked by me in writing at any. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

9. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.

10. I understand that 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.

11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

12. This authorization is valid as of the date I have signed below.

____
Name of Patient (Printed)

____ ____________________
Patient Signature Date