AUTHORIZATION FORM
REGARDING THE USE & DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the following use or disclosure of my health information:

Entity of Person Authorized to Make the Use / Disclosure:<u>1960 West Chiropractic</u>

> *In the event that 1960 West Chiropractic Center is entered in the space above, I understand that I may inspect or copy the health information to be used or disclosed. I further understand that the health information identified in the Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by this rule. The following also need to be completed:*
>
> *Will your practice be reimbursed, directly or indirectly, for the use/disclosure? Yes___No___*

Entity or Person **<u>To Whom</u>** the Use / Disclosure Should Be Made:____________________________

Description of Information to Be Used / Disclosed:____

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Purpose of the Use / Disclosure:____

Expiration Date / Expiration Event:____

I understand that I may refuse to sign this authorization and that treatment and payment cannot be conditioned upon my completion of this form. I understand that this authorization may be revoked in writing except to the extent that our practice has acted in reliance thereon.

Name:____

Signature:____ Date:__________________

If this authorization is being signed by a personal representative, describe the representative's authority to act for the individual:

MAKE A COPY OF THE SIGNED AUTHORIZATION AND PROVIDE TO THE PATIE