Paul D. Austin, DC, CCSP, DACNB
Austin Chiropractic Center, Inc.
362 S. McCaslin Blvd.
Louisville, CO 80027

Authorization for Use or Disclose of Protected Health Information

Patient name: ______________________________ Date of birth: ___________________

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All health care information in my health record

☐ Health care information in my health record relating to the following treatment or condition: ________________________

☐ Health care information in my health record for the date(s):___________________

☐ *Other (e.g., X-rays, bills), specify date(s):*__________________________________

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ *HIV (AIDS virus)*

☐ *Sexually transmitted diseases*

☐ *Psychiatric disorders/mental health*

☐ *Drug and/or alcohol use*

You may disclose this health care information to:

Name (or title) and organization: ____

Address: ____

City: ________________________State: ________Zip: ___________

Reason(s) for this authorization (check all that apply):

☐ at my request

☐ other (specify)
____
____

☐ check only if (practice/ facility) requests the authorization for marketing purposes

☐ check only if (practice/facility) will be paid or get something of value for providing health information for marketing purposes

This authorization ends:

☐ in 90 days from the date signed
☐ on (date) ______________
☐ when the following event occurs
____
(no longer than 90 days from date signed)

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II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study

  or

- To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Austin Chiropractic Center, Inc. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
- Fill out a revocation form. A form is available from the (practice/health care facility).

  Or

- Write a letter to the Austin Chiropractic Center, Inc.
  Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____________________________________ ____________________________

Patient or legally authorized individual signature Date

________________________________ ____________________________________

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)