

**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

Name (or title) and organization: _____

Address: _____

City: _____ State: _____ Zip: _____

You may 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 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:

**Paul D. Austin, DC, CCSP, DACNB
Austin Chiropractic Center, Inc.
362 S. McCaslin Blvd.
Louisville, CO 80027
Phone: 303-665-5405 Fax: 303-664-1697**

- 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)

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

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

- | | |
|--|---|
| <input type="checkbox"/> at my request | <input type="checkbox"/> check only if (practice/ facility) requests the authorization for marketing purposes |
| <input type="checkbox"/> other (specify)

_____ | <input type="checkbox"/> check only if (practice/facility) will be paid or get something of value for providing health information for marketing purposes |

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)