Authorization for Disclosure of Protected Health Information

I,_____, authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws[1], subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information(as specified below):

Name(s):

_____

Organization(s):

_____

Address:

_____

2. I authorize the following person(s) and/or organization(s) to receive my protected health information as disclosed by the person(s) and/or organizations(s) above.

Mainspring Chiropractic
16 Thornton Road
Oakland, NJ 07436

3. Specific description of the protected health information that I authorize for disclosure: Treatment notes, diagnostic test results, history/physical notes, narrative reports, billing data.

4. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signed: _____ Date:

_____

Name:

_____

Address:

Telephone: _____ Social Security No.:

Relationship or Authority of Personal Representative (if applicable)

This Authorization to disclose PHI constitutes a waiver of privilege per 76 O.S. §19. Photostatic copies of this Authorization carry the same authority as the original.