



Cascade Chiropractic

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FORM: Authorization for Use or Disclose of Protected Health Information

Patient name: _____ Date of birth: _____ SS#: _____

Requesting records from: _____

Phone / Fax: _____

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: Cascade Chiropractic

Address: 1420 King Street, Suite D City: Bellingham

State: WA Zip: 98229

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

at my request; 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; other (specify) _____

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)

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 Cascade Chiropractic Clinic, P.L.L.C. 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 Cascade Chiropractic Clinic, P.L.L.C.
- 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

Time

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)