CORE CHIROPRACTIC HIPPA DISCLOSURE

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

______All Patient Medical Records____

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Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

___Core Chiropractic & Physical Therapy__________________
Name of person/organization

Expiration Date of Authorization

This authorization is effective through __12/2010__unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

The use or disclosure requested under this authorization **will** [**will not**] result in direct or indirect remuneration to this office.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize_____Core Office Manager_______to use my protected information for the listed reasons.

Signature

____
Name of Patient (Print)

____
Signature of Patient **Date**

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient

____
Office Representative **Date**