

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Information to be Used or Disclosed

The information covered by this authorization includes: Your name, accumulated health records, and any information in your medical chart.

Persons Authorized to Use or Disclose information

Information listed above will be used or disclosed by:

HAZLEWOOD CHIROPRACTIC CLINIC

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Clinic's employees at minimal degree when deemed necessary, your private physician, hospitals, attorneys if authorized or by subpoena, referral board within our office and insurance carriers.

Expiration Date of Authorization

This authorization is effective through 12/31/2040 unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to HAZLEWOOD CHIROPRACTIC CLINIC. You should contact Dr. Craig Hazlewood to terminate this authorization.

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.

Name of Patient _____ Date _____

Signature of Patient _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____