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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I, ____ hereby authorize Carlyle Chiropractic Clinic, PC (the practice") to use and/or disclose to (Please check mark in front of only one item)
   ___my insurance company and/or ____lawyer or ___NA.
   The following specific protected health information: ___ Claim information to insurance company or ____, N/A if you do not have an insurance company.
2. I understand that this authorization is valid until I revoke it.
3. I understand that the purpose of use of the disclosure I am granting is to receive payment for services rendered.
4. I expressly acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization: List the limitations/criteria ____or _____NA If no limitations or criteria is requested by you.
6. I understand that this office will receive financial or in-kind compensation in exchange for using or disclosing the health information described above to receive payment for services rendered.
7. I understand that the authorizer may revoke this authorization in writing at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.
10. 10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
12. This authorization is valid as of _____/_____/_____, the date I have signed below.

___________________________________ ___________________________________
Name of individual (Printed) Signature of Individual

_____________________________________ ___________________________________
Signature of Legal Representative* Relationship

Witness: ____
*attorney-infact,Guardian,Parent if minor