

Authorization for the Use or Disclosure of Protected Health Information

Bovadilla Chiropractic Clinic 6023 S. Sheridan Rd Tulsa Ok. 74145

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As required by the Health Insurance Portability and Accountability Act of 1996 Bovadilla Chiropractic Clinic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize Dr Bovadilla the use or disclosure of the following health information that pertains to me.

ALL Medical Information History and Physical X-Ray Reports X-Ray Images
 Lab Reports Operative Report Discharge Summary Consultation Reports
 Other(explain) _____

for the following purpose<s>: Continue Treatments Request of patient or their legal representative Other _____

I authorize the following persons or organization to the use or disclosures of my health information:

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Bovadilla Chiropractic Clinic 6023 S. Sheridan Rd Tulsa Ok. 74145. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire when information is release or obtained or one year after the date signed whichever comes first.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in any way on whether I sign this authorization or not.

Signature

Date

REVOCAION SECTION

I hereby revoke this authorization.

Signature

Date