POJERO FAMILY
CHIROPRACTIC

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AUTHORIZATION DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

Name

1. I, hereby authorize Pojero Family Chiropractic to use and/or disclose to my insurance company, other insurance companies, past and present employers if applicable, my attorney and other attorneys, medical doctors, medical testing facilities and other health care professionals or to (if not already covered above) that have interest in my health care, following specific protected health information. Office notes, medical reports, test results, disability status, billing information, visit dates, insurance information and any other health information that have occurred at this office and/or obtained from other health care facilities by this office.
2. I understand that this authorization is valid for until revoke authorization or until minor becomes of legal age.
3. I understand that the purpose or use of this disclosure I am granting is to enable this office to communicate my health status to the above mentioned professionals and people.
4. I expressly acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:
6. I understand that the office/practice will not receive financial or in kind compensation in exchange for using or disclosing the health information described above with the exception of the normal reasonable and customary copy fee if applicable.
7. I understand that this authorization may be revoked by me and the authorizer, at any time, provided the revocation is in writing and revokes this refers to this specific dated authorization of which I will receive a copy. However I also understand that the revocation of this particular 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 reci pient and this information will no longer be protected by the federal privacy regulations.
9. I understand that my health care and payment for my health care will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, if I ask for it, that I will get a copy of this form after I sign it upon my request.
11. I understand that I may refuse to sign this authorization form.
12. This form was completely filled in before I sign it. I certify that all my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
13. This authorization is vaild as of the date I have signed below.

_____ _____

Name *Date*

_____ _____

Signature *Witness (office use only)*

_____ _____

Signature of Parent or Guardian (if minor) *Relationship*