

Authorization For The Use Of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization.
2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information: Mahler Family Chiropractic Center, Wyoming Valley family Chiropractic Center and/or Paul R. Mahler D.C.
3. I authorize the following persons (or class of persons) to receive my protected health information: Mahler Family Chiropractic Center, Wyoming Valley family Chiropractic Center and/or Paul R. Mahler D.C.
4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
6. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).
7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Mahler Family Chiropractic Center, nor will it affect my eligibility for benefits.

I certified that I have received a copy of the authorization:

PATIENT SIGNATURE _____ DATE ___/___/___