Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

- Letters of correspondence, Bi-Monthly Newsletter, Progress Reports, Sign IN and Welcome Sheets, New Patient, Birthday, and Referral Thank You Letters.

Persons Authorized to Use or Disclose information
Information noted above will be used or disclosed by:

- Dr. S. Matthew Kelly
- Celina Quintanilla

Expiration Date of Authorization
This authorization is effective through ____2015____ unless revoked or terminated by the patient or patients personal representative.

Right to Terminate or revoke authorization
You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for re-disclosure
Information that is disclosed under that 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 organization.

The use or disclosure requested under this authorization will not result in direct or indirect remuneration to this office.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize HOUSTON FAMILY CHIROPRACTIC CETER to use my protected information for the listed reasons.

Signature

_____
Name of patient (print)

_____
Signature of patient Date:

_____
Signature of patient representative

_____
Relationship of patient representative to patient

_____
Office representative Date:

Consent to Use and Disclose of Protected Health Information

Use and disclosure of your protected health information
Your protected health information will be used by Houston Family Chiropractic Center or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the notice of privacy practices for a more complete description of how your Protected Health Information may be use or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the notice prior to signing this consent. You may request a copy of the notice at the front desk.

Requesting a restriction on the use or disclosure of your information
Your may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to request, the restriction will be abiding with the office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not affect.

Reservation of right to change privacy practice
This office reserves the right to modify the privacy practices outlined in the notice

Signature
I have reviewed this consent form and give my permission to this office to use and disclose my health information in the accordance with it.

_____
Name of patient (print)

_____
Signature of patient Date:

_____
Signature of patient representative

_____
Relationship of patient representative to patient

_____
Office representative Date: