

Authorization to Use or Disclose Protected Health Information

Wellness Chiropractic

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email: Lewkovich@aol.com

To: _____

Address: _____

Phone: _____

Fax: _____

My date of birth: _____

My medical record #: _____

I, _____ give permission to you to release X-ray films,

MRI films, radiology report only, records, other _____

Please Fax reports as soon as possible for the purpose of review to:

Gary N. Lewkovich, DC

Jason A. Edwards, DC

Effective dates for this authorization: _____ / _____ / _____ through _____ / _____ / _____

This authorization will expire at the end of the above period.

Per HIPAA guidelines, I understand that the information disclosed above may, at some point, be re-disclosed to additional parties, by my authorization or subpoena. At that time, this information will no longer be under our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not affect my treatment, payment or enrollment in a health plan. Additionally, I understand my eligibility for benefits will not be affected whether or not I provide authorization to use or disclose protected patient health information.

Patient Signature: _____ **Date:** _____

Or authorized agent, Parent/guardian of patient, Spouse of patient, Other _____