Bill M. Macchi D.C., P.A.
ATLAS ORTHOGONAL CHIROPRACTIC

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (LAST, FIRST, MI)	*MEDICAL RECORD NUMBER*
ADDRESS	
CITY/STATE	*DATE OF BIRTH*

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

THE INFORMATION IS TO BE **DISCLOSED BY**:	AND **PROVIDED TO**:
NAME OF FACILITY	*NAME OF PERSON/ORGANIZATION/FACILITY*
ADDRESS	*ADDRESS*
CITY/STATE	*CITY/STATE*
PHONE NUMBER	*PHONE NUMBER*

- **PURPOSES OF DISCLOSURE:** *(Check all that apply)*

  - ☐ Further Medical Care
  - ☐ Personal Use
  - ☐ At the Patient's request
  - ☐ Attorney / Litigation
  - ☐ Insurance
  - ☐ Other: *(specify)*
  - ☐ School
  - ☐ Disability

- **HEALTH INFORMATION TO BE DISCLOSED**: *(Check all that apply)*

  - ☐ Only information related to (specify): _____

    _____
  - ☐ Only the period of events from _____ to _____
  - ☐ Other (X-Rays, Billing, etc.) _____

    _____
  - ☐ Entire Record

I, _____, hereby authorize the disclosure of information from my health record, as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that my treatment, payment, enrollment, and eligibility for care are not conditioned upon my providing this authorization except in such cases as may be necessary for claim review and appeal purposes.

I understand that I may revoke this authorization in writing at any time by contacting the Practice at the address listed above, except to the extent that action has already been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. (*Specify expiration date :* _____*).*

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	*DATE*
SIGNATURE OF LEGAL REPRESENTATIVE (state relationship to patient)	*DATE*