AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider, Dr. Jana Joshu Grimm, DC, to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):
Name:_____
Address:_____

Purpose: I authorize the release of my health information for the following specific purpose:
_____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: (check the applicable choice below)

I authorize the release of the following health information:
____ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
____ Only the following records or types of health information:
Please list _____.

Term: I understand that this Authorization will remain in effect:

____ From the date of this Authorization until _____ (date)
____ Until the Provider fulfills this request.
____ Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Dr. Jana Joshu Grimm, DC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Dr. Jana Joshu Grimm, DC at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the office of Dr. Jana Joshu Grimm, DC for answers to my questions about the privacy of my health information.

_____ _____ _____
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____
Name of Guardian/	Legal Relationship	Date

_____
Witness Representative

NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.