AUTHORIZATION
TO DISCLOSE OF PATIENT HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security # _____

As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.
I hereby authorize:

Barstow Community Hospital	Phone 760-256-1671	Fax 760-957-3385
RadNet	Phone 760-256-6541	Fax 760-256-6801

Other_____
and its employees to disclose my Protected Health Information to :

Scott L. Martin, D.C. Martin Chiropractic
225 E Buena Vista St, Barstow, CA 92311
Phone 760-256-2171 Fax 760-256-3937

Patient Health Information authorized to be disclosed:

_____ X-Rays w/Report	_____ MRI Report	_____ Patient Tx Notes
_____ Lab Results	_____ Reports	_____ History
_____Patient Referral	Other _____	

For the specific use or purpose of: Examination and Treatment by Dr. Scott Martin

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____.
This authorization will expire at the end of the above period. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond 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 the 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 condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature or Patient or Patient's Authorized Representative *Date*