AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I, _____, hereby authorize

Dr. Robert Bentley

to (check those that apply):

_☐_ Use the following protected health information, and/or

_☐_ Disclose the following protected health information to:

Name of Receiver: _____

Address of Receiver: _____

_____

Below, describe the information to be used or disclosed, including, but not limited to, descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.]

_____

_____

_____

This protected health information is being used or disclosed for the following purposes:

_____

This authorization shall be in force and effect until _____

[date/event that relates to the patient or the purpose of the use or disclosure]

at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Robert Bentley 2901 E 20th St Farmington NM 87402.

I understand that a revocation is not effective to the extent that Dr. Bentley has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Dr. Bentley will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

☐ Inspect or obtain copies (at a reasonable cost and within a reasonable time frame from the written request) of the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

☐ Refuse to sign this authorization.

The use or disclosure requested under this authorization may also result in direct or indirect remuneration to the Doctor Robert Bentley **and/or Bentley Chiropractic** from a third party.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority