HOLLAND CHIROPRACTIC & ACUPUNCTURE CLINIC
FREEMAN J HOLLAND, DC, DACAN, CAc, FASA
6295 W 38TH AVE, WHEAT RIDGE, COLORADO 80033.5055
TELE: 303.422.7767 FAX: 303.421.8359
eMAIL: HOLLAND-CHIRO@MSN.COM

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION: I voluntarily consent to and authorize my health care provider Freeman J Holland, DC, DACAN, CAc, FASA 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) (see additional recipients 1-5 on page 2):

Recipient #1: _____

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: I authorize the release of the following health information: (check the applicable box below)

☐ 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:

_____

NOTE: *Unless otherwise specified by law, we will release only that information which has been created by our office, our employees or agents, including chart notes, lab results, summaries and consultation reports.* Alcohol or drug use/abuse treatment, mental health treatment or HIV status or treatment will also not be released without a specific release. *Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities*

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

☐ From the date of this Authorization until the _____ day of _____, 20_____

☐ Until the provider fulfills this request.

☐ ☐ One Year ☐ Two Years ☐ Three Years

☐ 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. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.

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 the Holland Chiropractic & Acupuncture Clinic. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Holland Chiropractic & Acupuncture Clinic's Office of Compliance 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 Holland Chiropractic & Acupuncture Clinic Office of Compliance for answers to my questions about the privacy of my health information at 6295 W 38th Ave., Wheat Ridge, Colorado 80033.5055 or by telephone at (303) 422.7767.

_X_____ _____ _____

Signature Date Signature of Witness

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

_____ _____ _____

Name of Guardian/Representative Date Witness

_____

Legal Relationship

ADDITIONAL RECIPIENTS: I authorize my health care information to be released to the following recipient(s) (see primary recipient on page 1):

Recipient #2:_____

Address: _____

Recipient #3:_____

Address: _____

Recipient #4:_____

Address: _____

Recipient #5:_____

Address: _____