GEISE CHIROPRACTIC, L.L.C.

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, give permission to Geise Chiropractic LLC, medical services providers, and payors to disclose and release my protected health information described below to:

Name(s): Relationship:

_____ _____

_____ _____

Health Information to be disclosed (Check all that apply):

☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

OR

☐ My complete health record, as above, with the exception of the following information (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify) _____

_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

☐ All past, present, and future periods,

OR

☐ Date or event: _____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Printed Name of the Individual Giving this Authorization — If minor, patient's name

_____ _____

Signature of the Individual Giving this Authorization — Date

_____ _____

Witness of Office Personnel — Date

****If you wish to review our Privacy Notice, you can request this at the front desk**