Authorization for Information Disclosure

This for complies with HIPPA Privacy Rule

Patient Name:____Date:_______________

Patient Address:_______________________City:______________ST:______Zip:______

I hereby authorize:____

Name of physician's office/medical practice disclosing information

Requestor/Recipient Information

Tenafly Chiropractic Center
Ross M. Markowitz, D.C.
32 Washington Street Suite, 2A
Tenafly, NJ 07670

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire in six months or on the following date:_________________.**

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not to sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this information.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL;
DO NOT RELEASE_______.

____ _____________________

Signature of Patient or Authorized Representative (if applicable) *Date*

____ _____________________

Description of Representative's Authority (witness signature required) *Signature of Witness*