

Authorization For Use or Disclosure of Information, Payment And Consent Of Treatment

I, _____, hereby authorize

Dr. Jason C. Robeson and/or Robeson Family Chiropractic, Inc.

To (check those that apply)

___ Use the following protected health information, and /or

___ Disclose the following protected health information to:

Name Of Insurance Co. _____

For Purposes of this consent, "Protected Health Information" means any information, including but not limited to: Date of service, Type of service, Diagnosis, Daily Treatment records, Reports, Examination findings, X ray findings, my demographic information, created or receive by the Practice, that relates to my past, present, or future physical or mental health or condition: the provisions of health care to me; and either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

This protected health information is being used or disclosed for the following purposes: Information for the purpose of providing treatment to me for the purpose related to the payment of services rendered to me, referring out to another health care provider and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

This authorization shall be in force and effect until further written notice 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. Jason C. Robeson at 400 Pendleton Rd, Clemson, SC 29631**

I understand that a revocation is not effective to the extent that Dr. Jason C. Robeson 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 the federal or state law.

Dr. Jason C. Robeson 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 laws 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 **Dr. Jason C. Robeson and/or Robeson Family Chiropractic, Inc.** from a third party.

Signature Of Patient or Personal Representative

Date

Name of Patient or Personal Representation