PATIENT AUTHORIZATION FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize Mend Health of Maine PC to use and/or disclose the following specific protected health information to ***(Check All That Apply):***

- ❑ Medical Records/Diagnosis
- ❑ Complete Copy of Medical File
- ❑ X-Rays/ Imaging reports
- ❑ Chiropractic Visits
- ❑ Insurance Information/ Billing
- ❑ Other: _____

Reason for Release: _____

Name of Person/Agency:_____

Address: _____

Phone Number:_____

Fax Number:_____

PATIENT RIGHTS:

1. I understand that this authorization is valid for one year from signing date below.
2. I expressly/acknowledge that this authorization is voluntary.
3. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
4. I understand that this authorization may be revoked by me in writing at any time. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
5. I understand that I may receive a copy of the information, if requested in writing. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.
6. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

_____
Print Name

X_____ _____
Patient Signature or Date
(Parent/ Guardian of a Minor's) Signature