AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I HEREBY AUTHORIZE:

NAME OF DISCLOSING PARTY:

ADDRESS:

CITY, STATE, ZIP

PHONE

FAX

TO DISCLOSE TO:

NAME OF RECIPIENT	Patrick Tribble, DC
ADDRESS:	912 The Alameda
CITY, STATE, ZIP	Berkeley, CA 94707
PHONE	510-525-4825
FAX	510-524-6835

RECORDS AND INFORMATION PERTAINING TO:

PATIENT NAME:

DATE OF BIRTH:

ADDRESS:

CITY, STATE, ZIP

PHONE:

SPECIFIY RECORDS:

- ❑ Recent Medical/Chiropractic Records (Do not include billing records)
- ❑ Past Medical/Chiropractic Records (Do not include billing records)
- ❑ X-ray report and films _____
- ❑ MRI report and films _____
- ❑ CT report/films
- ❑ EMG, SSEP, and Nerve Conduction Study reports
- ❑ IME report
- ❑ OTHER (SPECIFY) _____

THE RECIPIENT MAY USE THE HEALTH INFORMTION AUTHORIZED ON THIS FORM FOR THE FOLLOWING PURPOSES: _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____.
REVOCATION: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A copy of this authorization is as valid as the original. The patient has a right to a copy of this authorization.

_____ _____

PATIENT SIGNATURE DATE