



Authorization for Use and Disclosure of Health Information

Requested by Austin Hills Chiropractic for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, Austin Hills Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who contribute to my care
- a means by which a third-party payer can verify that services billed were actually provided

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Rachel C. Bailey D.C., at 3839 Bee Caves Road, Suite 206, Austin, Texas 78746. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law and/or to refuse to sign this authorization.

I hereby authorize Austin Hills Chiropractic to disclose/share the following protected health information to the following entity:

(If you wish for Dr. Bailey to discuss your care with family members, physicians, or other individuals, please list their names on this line.)

Signature of Patient or Personal Representative

Printed Name of Patient

Description of Personal Representative's Authority

Date of Signing

Patient's Date of Birth