STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:
X-Rays, Personal Health Information, Records

Persons Authorized to Use of Disclose information
Information listed above will be used or disclosed by:
Wellness Concepts of Florida, L.L.C.

Name of person or organization
Dr. Greg G. Kotlarczyk, N.M.T., D.C.

Name of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

Name or person of organization

Name of person or organization

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Wellness Concepts of Florida. You should contact the Office Manager to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of patient (print of type)

Signature of Patient Date

Signature of Patient Representative

Relationship of Patient Representative to Patient