James D Martin D.C., C.C.S.P.
David J Martin M.S., D.C., C.C.S.P.

Valley CHIROPRACTIC CLINIC, INC

400 N Main St
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92-0139651
Phone: 907-373-2022
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PHI Use or Disclosure
Authorization & Log

Name:_____ Date of Birth:_____

Standard Authorization to Use or Disclose Protected Health Information (PHI)

Protected Health Information to be Used or Disclosed
The information covered by this authorization includes:

- ☐ Any information (no restriction on type of information)
- ☐ Specified information for disclosure: _____
- ☐ No information is to be disclosed

Persons Authorized to Use of Disclose Information

Information listed above will be used or disclosed by Valley Chiropractic Clinic, Inc.

Persons to Whom Information May Be Disclosed

- ☐ No one (do not disclose any information)
- ☐ Specified Person(s) of Organizations(s): :_____
  :_____

Expiration Date of Authorization

Unless revoked or terminated by the patient or the patient's parent of legal guardian, this authorization is effective though:

- ☐ Specific Date of Event _____
- ☐ No specific date or event for expiration is desired

Right to Terminate of Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Valley Chiropractic Clinic, Inc. Contact Cindi Martin, Office Manager, to revoke or terminate this authorization. If authorization is revoked, it won't have any effect on any actions Valley Chiropractic Clinic, Inc. took before they received the revocation.

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_____ _____
Patient, parent, or Legal Guardian Signature **Date Signed**

If signed by Parent of Legal Guardian

Printed Name of Signatory: _____
Relationship of Signatory to Patient: _____
Signatory Address: _____
Signatory phone Number: _____