STANDARD AUTHORIZATION OF USE.AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient: _____ **DOB:** _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES TODD BLACK, D.C., LLC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- ❑ I give permission to Todd Black, D.C., LLC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notifications, birthday/holiday cards, newsletters and other health related information.

- ❑ I give permission to Todd Black, D.C., LLC to use Internal Thank You Referral Board, Patient of The Month Display Board, Testimonial Book, and Patient Picture Display Board.

- ❑ If Todd Black, D.C., LL Ccontacts me by phone, I give 1hem permission to leave a phone message on my answering machine or voice mail.

- ❑ I give Todd Black, D.C., LLC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Todd Black, D.C., LLC permission to use and disclose your protected health information in accordance with the directives listed above.

Expiration Date of Authorization
This authorization is effective through ___ /___ /_____ unless revoked 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 Dr. Todd Black.

Signature of Patient _____ **Date** _____

Signature of Patient Representative _____ **Date** _____

Relationship of patient Representative to Patient _____