The Human Engine Clinic
A Gringeri Chiropractic Corporation
3461 Picadilly Drive, San Jose, CA 95118 | 408-984-7444

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

Street Address: _____

City: _____ State: _____Zip: _____

Phone Number (Circle one: mobile / land): _____

1. AUTHORIZES:

_____
Name of Health Care Provider

_____
Street Address

_____
City, State, Zip

TO RELEASE HEALTH INFORMATION TO:

Health Care Provider: Richard F. Gringeri, DC

Street Address: 3461 Picadilly Drive

City, State, Zip: San Jose, CA 95118

2. INFORMATION TO BE RELEASED:

- ❑ Medical History, Examination, Reports
- ❑ Treatment or Test
- ❑ X-Rays
- ❑ MRIs
- ❑ Lab Tests
- ❑ Other: _____
- ❑ Surgical Report
- ❑ Hospital Records
- ❑ X-Ray Reports
- ❑ MRI Reports
- ❑ Everything related to Type 2 diabetes
- ❑ Other: _____

Form 16-1 AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION (3/13) California Hospital Association.

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

3. PURPOSE/NEED FOR HEALTH DISCLOSURE: (Check all that apply)

- ❑ Further Medical Care
- ❑ Insurance Eligibility
- ❑ Legal Investigation or Actions
- ❑ Personal, at the request of the individual
- ❑ Changing Physicians
- ❑ Other: _____

4. I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans or healthcare clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

5. YOUR RIGHT WITH RESPECT TO THIS AUTHORIZATION:

a) Right to receive a copy of this authorization. I understand that if I agree to sign this authorization, which I am not required to do, that I must be provided with a signed copy of the form.

b) Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payments, enrollment in a health plan or eligibility for healthcare benefits on my decision to sign this authorization.

c) As a provider of Health Plan, the rule permits you to condition treatment, payment, enrollment in a health plan or eligibility for healthcare benefits on the signing of this authorization in the following circumstances:

   i) A healthcare provider may condition the provision of research-related treatment on the provision of an authorization to use and/or disclose an individual's health information for such research.

   ii) A health plan may condition enrollment in the health plan or eligibility for benefits on the provision of an authorization required prior to enrollment in a health plan, if:
   (1) The authorization is for the health plan's eligibility or enrollment determinations or for its underwriting or risk determination and,
   (2) The authorization is not for the use and/or disclosure of psychotherapy notes.

   iii) An entity subject to the Rule may condition the provision of healthcare that is solely for the purpose of creating health information for disclosure to a third party on the provision of an authorization for the disclosure of the health information to such third party.
   If you wish to make such a condition, you must include a description of the circumstances upon signing of this authorization.

6. RIGHT TO WITHDRAW THIS AUTHORIZATION:

I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: _____. I am aware that my withdrawal will not be effective as to uses and/or disclosure of my health information that

the person(s) and or organization(s) listed above have laredy made in reference to this authorization.

7. **DISCLOSURE OF DIRECT OR INDIRECT PAYMENT RECEIVED BY ANY PERSON OR ORGANIZATION AUTHORIZED TO USE OF DISCLOSE MY HEALTH INFORMATION:**
I understand that the following persons(s) or organization(s):
_____ Will Not be receiving payment, as described below, in connection with the use of disclosure of my health information.
_____ Will Be receiving payment as described below, in connection with the use or disclosure of my health information (describe amount or nature of any direct or indirect payment).

_____

_____

8. **EXPIRATION DATE:**
This authorization is good until the following date(s): _____

or events (specify event): _____

_____
(An expiration date is not required if the authorization is for research purposes indicated at the end of research.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am condemning that it accurately reflects my wishes.

9. **SIGNATURE OF PATIENT:**

X _____ Date: _____

If signed by person other than patient, state relationship and authority to do so:

Patient is:
❑ Minor ❑ Incompetent ❑ Disables ❑ Deceased

Authority:
❑ Custodial Parent ❑ Legal Guardian ❑ Executor or Estate Deceased
❑ Power of Attorney for Healthcare ❑ Authorized Legal Representative