Medical Records Release of Protected Health Information

I consent to the disclosure of my protected health information (PHI) for the purpose of treatment, payment or health care operations. My PHI refers to health and demographic information collected from me and created or received by my provider, and other health care provider, a health plan, my employer, a health care clearinghouse, or a third-party administrator. This PHI relates to my past, present and/or future physical or mental health and identifies me.

I hereby authorize David Hogg, ND to release by health care information to _____ for the purpose of obtaining reimbursement for health care provided.

I understand that I have the right to review the David Hogg, ND privacy notice for a more complete description of uses and disclosures and that I have the right to review the notice prior to signing this consent.

I understand that I have the right to request that David Hogg, ND restrict how my protected health information is used or disclosed to carry out treatment and payment of health care operations.

I further understand that David Hogg, ND is not required to agree to requested restrictions, but if David Hogg, ND agrees to a requested restriction, the restriction is binding on David Hogg, ND.

I understand I have the right to revoke this consent in writing except to the extent that the David Hogg, ND has already taken action in reliance on this consent.

I understand that David Hogg, ND reserves the right to change the privacy practices described in their Privacy Notice and that I may obtain a revised notice by calling the office and requesting a revised notice be sent in the mail, or requesting one at my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative/Relationship to Patient

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Date