Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing and Communication

I authorize Belville & Associates Chiropractic Clinic (hereinafter "BACC") to use or disclose information (described below) about my, my child's, or other medical condition.

The protected health information to be used contains my Name, Age, and "Chiropractic Journey," or testimony.

I hereby authorize the use and disclosure of the Protected Health information (detailed above) to be used or disclosed by BACC's communication/ marketing department or anyone authorized by BACC for marketing and promotional purposes. This authorization will expire five years after the date submitted to BACC.

This Authorization may be revoked at any time to the extent that use or disclosure has not already occurred prior to your request for revocation. Please refer to the Belville & Associates Chiropractic Clinic's Notice of Privacy Practices. In order to revoke the authorization, the patient/parent/legal guardian must notify BACC in writing at P.O. Box 3838, Oshkosh, WI 54903 or by telephone (920) 230-2525.

BACC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The Protected Health Information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus is no longer protected by the federal privacy regulations.

The text/quotes specified above become the property of BACC or it's representatives.

This Authorization is given without promise of compensation. The parent/legal guardian and the patient release to BACC any right/ title and/interest of any kind they may have in the information or images produced.

By submitting my testimony electronically, I authorize BACC to use or disclose any medical information disclosed in this Authorization.

ADDITIONAL INFORMATION REGARDING THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

BELVILLE & ASSOCIATES CHIROPRACTIC CLINIC recognizes the patient's right to confidentiality of protected health information in accordance with the federal privacy rule and Wisconsin law. Patients should be aware of the following information when requesting the release of protected health information:

Right to Refuse to Sign this Authorization

A patient has the right to refuse to sign this authorization form and BELVILLE & ASSOCIATES CHIROPRACTIC CLINIC will not condition treatment or payment of claims upon the provision that the patient sign this authorization form.

Right to Inspect or Copy the Information to be Used or Disclosed
A patient has the right to inspect or obtain a copy of the protected health information to be used or disclosed by signing this authorization form and may arrange a time to do so by contacting the medical records department.

Right to Receive a Copy of this Authorization
A patient has the right to request a copy of the signed authorization.

Right to Revoke Authorization
A patient has the right to revoke an authorization at any time by giving a written notice of revocation to the Privacy Officer listed below. Revocation of this authorization will not apply to information that has been released in compliance with this authorization prior to the receipt of the written notice of revocation. The revocation will not apply to the patient's insurance company when the law provides the insurer with the right to contest a claim under the patient's policy.

Redisclosure of Information by Recipient
Any disclosure of protected health information carries with it the potential for an unauthorized redisclosure. If the person(s) and/or organization listed in Section 3 are not health care providers, health plans or health care clearinghouses subject to the federal privacy rule, the protected health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and may be redisclosed without obtaining my authorization.

Multiple Releases of Information
A patient may request multiple releases of information described on the authorization form (Section 6). However, all releases based on this form are limited to records dated up to and including the date of the patient's signature unless otherwise specified. A new authorization is necessary for release of information related to care provided after the date of the patient's signature, unless the authorization specifies release of future records of a specific test or a specific clinic appointment.

Marketing
If BELVILLE & ASSOCIATES CHIROPRACTIC CLINIC uses this authorization for marketing activities, the patient will be informed if BELVILLE & ASSOCIATES CHIROPRACTIC CLINIC receives any direct or indirect payment in connection with the use or disclosure of the patient's information.

HIV Test Results
A patient's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Who May Sign Authorization
Wisconsin Statutes recognize the need for informed consent. Generally, all patients 18 years of age and over must sign for release of their own medical records unless the following conditions apply:
- The patient is incompetent.
- The patient is disabled and cannot sign the form.
- The patient is deceased. (A surviving spouse or personal representative of the estate may sign. If no such person exists, then an adult member of the immediate family may sign).

Patients less than 18 years of age must sign for release of their medical records when:
- The patient is 14 years of age or older and the records involve mental health treatment or developmental disabilities (parents retain the right to access this information)
- The patient is 14 years of age or older and the records involve HIV test results
- The patient is 12 years of age or older and the records involve alcoholism or drug dependence
- The patient is an emancipated minor who is married or in the military
- The patient's records for release include abortion procedure.

All persons signing for release of protected health information on behalf of a patient must state their relationship to the patient and provide proof of their legal authority to act on behalf of the patient (Section 7).

Privacy Officer: AMANDA BELVILLE, 440 N. KOELLER STREET P.O. BOX 3838, OSHKOSH, WI 54903, AMANDAB@BELVILLECHIRO.COM

NOTE TO RECIPIENT OF INFORMATION:
This protected health information has been disclosed according to federal and state privacy rules. Unless you have further authorization, these rules may prohibit you from redisclosing this information without the specific written consent of the patient or the patient's legal representative.