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Mercer County Chiropractic & Wellness, LLC

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P 419-586-8600 | F 419-586-7881

CONSENT TO USE AND DISCLOSE HEALTH PROTECTED INFORMATION

I, _____, give permission for Mercer County Chiropractic & Wellness LLC, medical service providers, family members, and payors to disclose and release my protected health information described below:

Name(s)/Phone Number	Relationship
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (check one):

- ☐ My complete health records (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing, for all conditions)
  --OR--
- ☐ My complete health records, as above, with the exceptions of the following information (must specify):
  _____
  _____

  This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims and payments purposes, or related reasons.

This authorization shall be effective (check one):

- ☐ All past, present, and future periods
  --OR--
- ☐ Date span or event: _____
  Unless I revoke it. (You may revoke this authorization in writing at any time by notifying year health care providers, preferrable in writing).

_____	_____
Printed Name of the Individual Giving Authorization (Patient, Parent, Guardian)	If **minor**, patient's name
_____	_____
Signature of the Individual Giving Authorization (Patient, Parent, Guardian)	Date
_____	_____
Witness (Office Personnel)	Date

If you wish to review our Privacy Notice, you can request this at the front desk