



Bend Healing Arts Center, Randy Weinreb, L.Ac.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff to (check all that apply):

- X use the following protected health information to file your claims with your insurance carrier(s), and/or

- X disclose the following protected health information to Total Health Claim Solutions, LLC P.O. Box 1369, Bend, OR 97709, Phone # 541-617-0515

You can call me at work to discuss my condition? YES _____ NO _____

You can leave a message at work about my condition? YES _____ NO _____

You can discuss with my spouse about my condition? YES _____ NO _____

This protected health information is begin used or disclosed for the following purposes:

Processing your medical claims

This authorization shall be in force and effect until patient's account is inactive for more than one year, at that time patient will sign another updated authorization.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use of disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party.

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative