• S O H M A •
INTEGRATIVE HEALTH CENTER

HIPAA Authorization

1. I hereby authorize SOHMA Integrative Health Center (“SOHMA”) to use and/or disclose the protected health information about me described below ("PHI") to M & T Wellness Solutions, Inc.(“M&T”); Back to Life Chiropractic (“Back to Life Chiropractic”) and/or to Back to Life Integrated Medicine (“Back to Life”) in this HIPAA Authorization to Use and Disclose Protected Health Information (hereinafter “Agreement.”)
2. I am informed and aware that SOHMA, M&T and Back to Life Chiropractic and Back to Life are Affiliated Medical Centers (collectively “Affiliates”). I understand that the Affiliates may need to utilize and share information on an as needed basis. I understand the relationship between the Affiliates and authorize the disclosure of my PHI on an as needed basis.
3. The PHI that may be used and/or disclosed is:
    a. Full or last name and initial;
    b. All geographical identifiers smaller than a state, except for the initial three digits of a zip code if, according to the current publicly available data from the U.S. Bureau of the Census: the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000
    c. Dates (other than year) directly related to an individual;
    d. Phone Number, fax or email address;
    e. Social Security numbers;
    f. Medical record numbers;
    g. Health insurance beneficiary numbers;
    h. Account numbers;
    i. Device identifiers and serial numbers;
    j. Biometric identifiers, including finger, retinal and voice prints;
    k. Any other unique identifying number, characteristic, or code except the unique code assigned by the investigator to code the data
4. The PHI may be used and/or disclosed for the following purpose: for the treatment of my injuries and my ongoing health and wellness plan.
5. This authorization shall remain in effect until: one year from the date of execution of this agreement
6. SOHMA will be receiving health information under this authorization and may receive direct or indirect remuneration in exchange for disclosing the health information.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form.
8. I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time, except to the extent that SOHMA has acted in reliance upon it, by sending written notification to: NAME & ADDRESS
9. I understand that I have the right to refuse to sign this authorization.
10. I understand that PHI used or disclosed pursuant to this authorization may be disclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

_____ _____

Patient’s Name (Printed) Date

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Patient or Guardian’s Signature