Section II: Your rights concerning this authorization:

1. You may refuse to sign this authorization. We will not condition treatment on whether you sign the authorization unless the authorization is for the use of disclosure of information for research related treatment, or unless your treatment is solely for the purpose of disclosing information to a third party (example; an employment physical).
2. You may revoke this authorization at any time unless we have taken action in reliance on the authorization. To revoke the authorization, you must submit a written request to:
   RUDDELL CHIROPRACTIC CLINIC
   1117 16TH AVENUE
   LEWISTON, ID 83501
3. I nformation disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by applicable law.

Section III: To be completed by the individual or the individual's personal representative.

I have read this authorization. I do hereby authorize the use or disclosure of my protected heath information as described above.

Signed by:

______________________________ Date:________________
(Individual)

____
(Personal representative, if applicable)

____
(Description of personal representative's authority)

People I have authorized Ruddell Chiropractic Clinic to release information about my medical records to:

1.________________________ 4.________________________

2.________________________ 5.________________________

3.________________________ 6.________________________