CHIROPRACTIC NATURALLY, PLLC

A Family Wellness Center

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Medical Records)

Patient Name: ____ Date of Birth: ________________________

Address: ____

I authorize ____ ("the care provider") to use or disclose my protected health information (medical records) described below to: (Name and Address of person/entity)

____

____

For the following purposes: ("at patient request" is sufficient) ____

Dates of care: ____

__________ Copy of the complete Medical Record (**including all outside care provider records**)

__________ Other ____

I have been fully advised of my rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and I intend for this authorization to satisfy the requirements of HIPPA and the rules and regulations relating to that act. In that regard, I certify that I consent to the release of my records to the above named requestor and that the release of my entire medical records is the minimum disclosure necessary to satisfy this request.

I understand that I may inspect or copy the protected health information described in this authorization.

I understand that this authorization may be revoked in writing and delivered to the Health Information Department of the care provider at any time, and that the care provider must cease using this authorization, except that the care provider may complete any actions it initiated in reliance on this authorization and prior to my revocation.

I understand that the information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that the care provider shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.

I understand that by authorizing this release of my medical records I also release the care provider from all legal responsibility or liability that may arise from the release of these medical records.

Date: ________________________

____
Signature of patient or representative

____
Authority of representative (parent of minor, guardian, etc)
Copies may be attached of documentation

EXPIRATION: This authorization will expire on (date or event): _________________________________. If no date or event is specified, the authorization shall expire six months from the date it was signed. A photocopy of this authorization shall be considered as effective and valid as the original. A copy of this authorization shall be provided to the patient or representative when signed.