Great Health Chiropractic

The Journey To Great Health Starts with Us

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize _____ _____ _____
name of facility address

to release a copy of the medical information for:

_____ _____ to:_____
name of patient ss# date of birth name of facility

_____
address of facility

Evaluation & Treatment

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

_____ All hospital records
_____ Transcribed hospital records
_____ Medical records needed for continuity of care
_____ Most recent five year history
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Clinician office chart notes
_____ Physical therapy records
_____ Emergency and urgency care records
_____ X-Rays
_____ Other_____

_____ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

_____ HIV/AIDS - related records*
_____ Genetic testing information*
_____ Mental health information*

***Must be initialed to be included in other documents**

_____ Drug/alcohol diagnosis, treatment or referral information**

** **Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.**

_____ This authorization is limited to the following treatment:_____
_____ This authorization is limited to the following time period:_____
_____ This authorization is limited to a worker's compensation claim for injuries on:_____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
date signature of patient

_____ _____
date signature of person authorized by law