HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date:_____

Clinic Location(s) Authorized to Make the Requested Disclosure: _____

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

I authorize the release of my medical information specified below from the above listed Chiro One Wellness Center Clinic Location ("Chiro One") to:

Name of Person or Entity whom Chiro One May Make the Requested Disclosure:

_____

Address:

_____

Phone: _____ **Purpose for Disclosure:** _____

Date Range: From _____ to _____.

RECORDS TO BE RELEASED

☐ Entire Medical Record/Complete Patient File

If you are not requesting the entire medical record/complete patient file, please select or list specific documents to be requested **(check all that apply)**:

- ☐ Patient Intake Paperwork
- ☐ Patient Signed Consents
- ☐ X-Ray Films
- ☐ Physician Notes
- ☐ Correspondence
- ☐ Examinations/Consultations
- ☐ Treatment Plans/Prescriptions
- ☐ Reports
- ☐ Bills/Invoices/Payments
- ☐ Other: _____ *(Please list.)*

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METHOD OF DELIVERY

(Please select only one.)

☐ U.S. Mail ☐ Fax*

☐ Email* ☐ Other: _____

***Records Disclosed by Email or Fax**: I authorize the above requested records to be disclosed electronically to the following email address or fax number:

Email or Fax Number: _____ **Patient Initials:** _____

Email or Fax Acknowledgement:

I, the undersigned, warrant that I am the only person or entity that has access to the email address or fax number as provided above.

Name: _____ **Signature**: _____

(*Person or Entity Receiving Email or Fax)*

I understand that:

- I am not required to sign this Authorization, and my medical provider may not condition treatment, payment for treatment, enrollment or eligibility for benefits on whether I sign this Authorization.
- This Authorization will expire one year from the date of signature below. I may revoke this Authorization at any time in writing to the healthcare provider, except to the extent Chiro One has already relied on my authorization, and Chiro One has not had a reasonable opportunity to act when it receives the revocation.
- Federal privacy regulations will no longer apply to the information disclosed, and the information disclosed to the recipient may be re-disclosed to others.
- A copy of this Authorization is as valid as the original Authorization.
- I am entitled to a copy of this Authorization.

_____ _____

Patient Signature Date

_____ _____

Printed Name Relationship to Patient