AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO FAMILY CHIROPRACTIC CLINIC

PATIENT:

_____ _____

Name of Patient/Previous Names | Date of Birth/Medical Record Number

_____ _____

Street Address/PO Box Number | City, State, Zip Code

AUTHORIZES THE RELEASE OF PROTECTED HEALTH INFORMATION:

From:

_____
_____
_____
_____

To:

FAMILY CHIROPRACTIC CLINIC
15574 Edgewood Drive Suite 102
Baxter, MN 56425
Fax: 218-829-4855 Phone: 218-829-2665

INFORMATION TO BE RELEASED:

_____ Information necessary for Continued Care
_____ History and Physical
_____ X-rays and X-ray Reports
_____ MRI Reports
_____ Progress Notes
_____ Discharge Summary
_____ Consultations
_____ PT/SP/OT
_____ Immunizations
_____ EKG/EMG/EEG
_____Operative/Procedure Report
_____ Pathology Report
_____ Labs
_____ ER/UC
_____ Other_____

In compliance with Wisconsin and Minnesota Statues which require special permission to release otherwise privileged information, please release records pertaining to:

_____ Alcohol Abuse or test results
_____ HIV test results, AIDS or AIDS-related disease
_____ Developmental Disabilities
_____ Mental Health
_____ Drug Abuse or test results
_____ Sexually Transmitted Disease
_____ Other_____

THIS DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):

_✓_ Further Medical Care
_____ Relocation/Moving
_____ Changing Physicians (explain)_____
_____ Work Comp
_____ Attorney/court case
_✓_ At the request of an individual
_____ Insurance
_____ Other_____

REDISCLOSURE NOTICE: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer protected by Federal Privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this authorization by notifying the practice in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact: Family Chiropractic Clinic at (218)829-2665. I am aware that my revocation will not be effective as to uses and/or disclosure of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until _____

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

INDIVIDUAL'S SIGNATURE:

_____

Date: _____

REPRESENTATIVE'S SIGNATURE (If applicable):

_____

DESCRIPTION OF RELATIONSHIP:

____Parent ____Guardian ____POA for Health Care
____Spouse/Adult Family of Deceased Patient