HIPAA AUTHORIZATION TO RELEASE CHIRO ONE RECORDS

Date:_____

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

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

Address:_____ **Phone:** _____

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

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

_____

Address:

_____

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

Records Date Range: From_____to_____.

RECORDS TO BE RELEASED*

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
- ☐ Other: _____ *(Please list.)*
- ☐ Examinations/Consultations
- ☐ Treatment Plans/Prescriptions/Treatment Recommendations
- ☐ Reports
- ☐ Bills/Invoices/Payments
- ☐ Financial Commitments

***There may be fees for obtaining copies of medical records**

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METHOD OF DELIVERY

(Please select only one.)

☐ U.S. Mail ☐ Fax*

☐ Email* ☐ Other: _____

***Records Disclosed by Email or Fax**: You understand that it is Chiro One's policy to send records by U.S. Mail. Despite that, you have verified that the recipient's email or fax is secure and that the recipient is the only person or entity that is authorized to access the email or fax. You hereby release Chiro One from any claims that this email or fax may not be private to the recipient, and you specifically request Chiro One to email or fax the above requested records to the following email address or fax number:

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

You understand that:

- The information in my record may contain information regarding sexually transmitted diseases or HIV/AIDS. Your record may also contain information about mental health services or treatment for alcohol and/or drug abuse.
- You are not required to enter into this Authorization, and Chiro One may not condition treatment, payment for treatment, enrollment or eligibility for benefits on whether you sign this Authorization. Chiro One is allowed by law to disclose information regarding treatment, payment, or health care operations without my consent.
- This Authorization will expire one year from the date of signature below. You may revoke this Authorization at any time in writing to Chiro One, except to the extent Chiro One has already relied on your authorization and 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.
- You are entitled to a copy of this Authorization.

_____ _____

Patient Signature Date

_____ _____

Printed Name Relationship to Patient