STEELE CHIROPRACTIC
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Authorization for the Release of Medical Records and PHI

Patient Name/Chart #: _____ Date of Birth: _____

I hereby request and authorize **STEELE CHIROPRACTIC**

_____**To Disclose information to** _____**To Receive Information from**

Name/Provider: _____

Address: _____

City/State/Zip_____

Phone: _____ Fax: _____

Information to be disclosed includes copies of:

_____Office Notes/History _____Radiology Reports/Images

_____Billing and Accounting _____Lab Results

Dates requested: _____ to _____

I hereby authorize and request my information to be sent/received by/from Steele Chiropractic. This authorization is in effect until:

Date: _____/_____/_____ _____until I am no longer a patient

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, HIV/AIDS, abortion, or mental health treatment. Separate consent must be given before this information can be released.

____ I consent _____ I do not consent

Signature of Patient or Authorized Representative: _____

Date: _____

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

STEELE CHIROPRACTIC

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it, if requested. A copy of this authorization is as valid as the original.

_____Date: _____
Signature of Patient

If the patient is a minor or unable to sign, please complete the following:

_____ Patient is a minor: _____ years of age

_____ Patient is unable to sign because: _____

_____Date: _____
Signature of Legal Representative
If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

_____Date: _____
Printed Name of Representative/Relationship (i.e. parent, guardian, court order)

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_____I hereby revoke this authorization for release of my medical records/PHI:

Signature of Patient or Authorized Representative: _____

Date: _____

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