ASCENT CHIROPRACTIC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please read all information and instructions before completing and signing the authorization form

Patient's Name _____ Birthdate_____
(please print) LAST FIRST MI

Are medical records filed under another name? _____ Phone No._____

SEND INFORMATION TO: Person / Medical Provider _____

Street Address: _____ City, State, Zip:_____

Phone No. _____ Email: _____

TYPE OF MEDICAL INFORMATION REQUESTED:

- ☐ All Records ☐ Billing Records ☐ Other _____
- ☐ My health information relating only to the following treatment or condition _____
- ☐ My health information relating only for the following date(s) _____

REASON FOR REQUEST:

- ☐ Personal ☐ Transfer of Care ☐ Disability ☐ Insurance ☐ Continuing Care
- ☐ Other (please explain): _____

PATIENT RIGHTS:

1. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations.
2. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits).
3. You have the right to revoke or cancel this authorization, in writing, at any time.

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PROVIDER OR HEALTHCARE FACILITY.

This authorization expires _____(date or event). Authorization will expire in 90 days if not otherwise specified.

My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization.

Patient signature _____ Date _____

Parent or Legal Guardian_____ Date _____

Relationship to patient, if other than patient_____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)