Authorization for Release of Medical Records

I hereby voluntarily authorize the use and/or disclosure of my health information as described below. I understand that if the entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation.

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Heartland Chiropractic and Wellness Center. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the organization.

I understand my healthcare and payment for my healthcare will not be affected by this authorization.

Patient Identification	Name (first, middle, last): _____ Date of Birth: _____ Last 4-digits of SS# _____ Any previous names under which records may be kept: _____
Provider (Who is to receive the information?)	☑ Heartland Chiropractic and Wellness Center – all physicians and practitioners. ❑ Name of Other Entity: _____ Address: _____
Provider (Who is to disclose the information?)	Name of Other Entity: _____ Address: _____ Phone: (_____) _____ Fax: (_____) _____
Purpose of Release (check <u>all</u> that apply)	❑ At request of the patient (or legal representative) ❑ At request of patient's parent or legal guardian ❑ Other (please specify): _____
Information (What information should be released?) (check <u>all</u> that apply)	❑ Medical Records ❑ Labs ❑ X-rays Report + CD Images ❑ MRI Report + CD Images ❑ Other _____ Dating from: _____ to: _____ ❑ Other (please specify): _____

Signature of patient or legal representative: _____ Date: _____

Relationship to patient, if other than self: _____

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse treatment records or by state law for mental health records, federal requirements (42 CFR Part 2) and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties ay attach for unauthorized disclosure of alcohol/drug abuse treatment or mental health information.

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