

Authorization for Release of Patient Information

Patient Name _____ Date of Birth _____

I hereby authorize _____
Name Address City State Zip
Telephone Number _____

to disclose the above named individual's health information as described below:

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

- Most recent history and physical
- Laboratory reports
- Radiology/Imaging reports
- Radiology films
- Other _____
- Consultations
- Progress notes
- Entire medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used the following individual or organization:

Name Address City State Zip
Telephone Number _____

Description of the purpose of the use and/or disclosure:

- Continuing Care
- Consultation
- Legal purposes
- Other: Please describe: _____
- Second Opinion
- Insurance
- Personal Use
- Social Security/Disability

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand The Gray Chiropractic Center may charge a processing fee for this service. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event).

I understand I may revoke this authorization at any time by notifying the Gray Chiropractic Center. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative Date

Printed name of Patient or Patient's Representative

Relationship to Patient or Legal Authority (attach supporting documentation)