Gray Chiropractic Center

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Authorization for Release of Patient Information

I give permission for my health information to be released **from:**

Name _____

Mailing Address _____ State _____Zip _____

Email Address _____ Phone _____ Fax _____

My health information should be sent **to:**

Name _____

Mailing Address _____ State _____Zip _____

Email Address _____ Phone _____ Fax _____

This is a description of the information I want released (check any that apply):

___Most recent history and exam ___Radiology/Imaging reports

___Progress notes ___Radiology films

___Entire medical record Other: _____

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

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.

I'm requesting this record transfer for the following purpose:

___Continuing Care ___Social Security/Disability

___Second Opinion ___Personal Use Other (Please describe): _____

I understand I may inspect or copy the information to be used or disclosed. I understand information released by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand this authorization will stay in effect until I revoke it by notifying Gray Chiropractic Center in a written request that includes a signature and date later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Patient's Printed Name: _____Date of Birth: _____

Signature: _____ Today's Date: _____

If you are filling this out on behalf of patient, please attach supporting documentation of your legal authority.