



**BATTLE GROUND
CHIROPRACTIC**

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ Preferred Name _____
Mailing Address _____ Birth Date _____
City _____ State _____ Zip _____ - _____ Gender _____
Daytime Phone () _____ Evening Phone () _____

I authorize you to **OBTAIN** health care information **FROM:**

I authorize you to send disclose/discuss health care Information **TO:** Self/Patient

Name

Title/Organization

Street/Box

City / State / Zip

Name

Title/Organization

Street/Box

City / State / Zip

You may use/disclose the following information:

- All health care information in my medical record
- Treatment/Chart Notes
- Radiology/Imaging – date(s) or type(s) _____
- Other _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released **unless** I have initialed the lines below:

EXCLUDE the following information from the records released (Please initial)

_____ HIV, HIV-related illness, AIDS, AIDS-related illness _____ Sexually transmitted diseases
_____ Psychiatric disorders / Mental health treatment _____ Drug and/or alcohol use

Reason for Disclosure:

Referral or Second Opinion Transfer of care Other _____

This authorization ends 90 days after the date it is signed, or

On (date) _____ When the following event occurs _____

I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Battle Ground Chiropractic based upon this authorization. I may revoke this authorization by writing a letter to Battle Ground Chiropractic, or filling out a revocation form, available from Battle Ground Chiropractic.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized representative signature

Date

Relationship to patient (if not signed by patient)

Printed name if signed on behalf of patient