



## Hillclimb Chiropractic Clinic

### **Authorization to Use Disclose and Release Protected Health Information**

Matt Brown-Ruegg, DC PS | 1409 5<sup>th</sup> Ave | Seattle WA 98101 | 206-624-3590 | www.hillclimbclinic.com

**I authorize Hillclimb Chiropractic Clinic to use or disclose a copy of the specific health information described below regarding:**

**Patient Name (please print):** \_\_\_\_\_

Other/Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Information to be release TO:**  Another Clinic  Self

Recipient Name: \_\_\_\_\_ Bellevue Pain Institute

Address to mail records: \_\_\_\_\_ 12360 NE 8<sup>th</sup> Street Suite 200 Bellevue WA 98005

Phone Number: \_\_\_\_\_ 425-999-9633 | Fax: \_\_\_\_\_ 888-899-4360

**Information to be released FROM:**

Physician or Clinic Name: \_\_\_\_\_ Hillclimb Chiropractic Clinic

Address to mail records: \_\_\_\_\_ 1409 5<sup>th</sup> Ave Seattle WA 98101

Phone Number: \_\_\_\_\_ 206-624-3590 | Fax: \_\_\_\_\_ 206-583-4139

\*Records will be put on a USB drive or CD and mailed. We cannot electronically send records due to HIPAA.

**Information to be released:**

Radiology Report  Films  Chart Notes / Intakes  Other: \_\_\_\_\_

Dates of Service to Release Information for: \_\_\_\_\_ to \_\_\_\_\_ OR  All Dates

**Terms:** This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, Alcohol and/or drug abuse, mental health conditions or other sensitive information. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Hillclimb Chiropractic Clinic based upon this authorization. Revoke this authorization by sending us dated written notice. Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient Name- Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient / Patient Representative Name- Print

\_\_\_\_\_  
Relationship if not signed by patient

**IF A PATIENT HAS REACHED HIS/HER FOURTEENTH BIRTHDAY, ONLY THE PATIENT MAY AUTHORIZE DISCLOSURE. THIS AUTHORIZATION TERMINATES 180 DAYS FROM THE DATE SIGNED.**