HILLCLIMB
CHIROPRACTIC CLINIC
Chiropractic | Naturopathic | Acupuncture | Massage

Hillclimb Chiropractic Clinic

Authorization to Use Disclose and Release Protected Health Information

Matt Brown-Ruegg, DC PS | 1409 5th 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: Graham Rehabilitation and Wellness

Address to mail records: 1215 4th Avenue Suite 1000 Seattle WA 98101

Phone Number: 206-622-9001 | Fax: 206-622-4311

Information to be released FROM:

Physician or Clinic Name: Hillclimb Chiropractic Clinic

Address to mail records: 1409 5th 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.