Hillclimb Chiropractic Clinic

Authorization to Use Disclose and Release Protected Health Information

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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: ____

Address to mail records: ____

Phone Number: ________________________ | Fax: ________________________

Information to be released FROM:

Physician or Clinic Name: ____

Address to mail records: ____

Phone Number: ________________________ | Fax: ________________________

*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

Reason for records release: ☒ Transfer of care

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.