HILLCLIMB
CHIROPRACTIC CLINIC

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RECORDS RELEASE AUTHORIZATION

I hereby request that my records be released:

Information to be released to/from: _____
Location or Hospital / Physician Name

_____
City, State

_____
Phone / Fax

Read Carefully: I authorize you to furnish all requested medical information to Hillclimb Chiropractic Clinic. I understand that my express consent is required for you to release information relating to sexually transmitted disease, mental illness, and /or drug/alcohol abuse, pursuant to Washington Law, RCW 70.24 ET.SEQ.

☐ Radiology ☐ Reports ☐ Films Date Taken: _____

☐ Records Dates: _____

☐ Other *(See Below)* _____

_____

Patient Name ***(please print*** _____

Other/Maiden Name _____

Birthday _____ _____

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. Two ways to revoke this authorization are: 1) Fill out a revocation form (available from our office), 2) Write a letter to us. Once healthcare 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 individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship to patient

IF A PATIENT HAS REACHED HIS/HER FOURTEENTH BIRTHDAY, ONLY THE PATIENT MAY AUTHORIZE DISCLOSURE. THIS AUTHORIZATION TERMINATES 90 DAYS FROM THE DATE SIGNED.