BATTLE GROUND CHIROPRACTIC, PS * 1710 W Main St, STE 101 * Battle Ground, WA 98604 * (360)687-3181 * (360)687-1992/fax

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**:

_____
Name

_____
Title/Organization

_____
Street/Box

_____
City / State / Zip

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

_____
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

There may be fees for providing copies.