Allen Chiropractic
Wellness Center

1018 South Westwood Blvd. Suite 5, Poplar Bluff, MO 63901
573-778-0500 FAX:888-972-7541

PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name _____ Date of Birth: _____

Address _____

Phone Number _____ Chart Number _____

I request and authorize Allen Chiropractic Wellness Center to use and/or disclose my:

- ☐ **Protected Health Information (PHI)**: PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services

I authorize disclosure of the following information from my medical record: *(detailed description with dates)*

_____

_____

_____

Release records to:

Name: _____ Telephone: _____

Address _____

Purpose(s) for the release:

Note: If the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose.

_____

_____

I Understand that:

- Treatment will not be conditional on whether I sign this Authorization and is voluntary
- If I sign this authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice.

Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the authorization.

- This authorization will expire 3 years from today's date.
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.

Signature(s)

Patient signature _____ Date _____

Representative signature _____ Date _____

Print Name _____

Relationship to Patient _____

FOR OFFICE USE ONLY	
Verification method:	Date
Verification by:	

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