Allen Chiropractic
Wellness Center

1018 S. Westwood Blvd., Ste. 5
Poplar Bluff, MO 63901

Phone: 573-778-0500
Fax: 888-972-7541

www.allenchiropracticwellness.com

** Records request **

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives Allen Chiropractic Wellness Center permission to obtain and use your Protected Health Information (PHI) to carry out treatment, receive and use as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to revocation of this consent are covered by this consent.

Patient Signature_____ **Date**_____

This request expires 3 years from Today

Records requested:

Patient Name _____ DOB _____

Medical Records Needed:

_____ X-Rays / MRI - Films or disc
_____ Radiology Reports
Approximate date done _____ Body part(s) _____
_____ Lab Reports

Studies Needed:

_____
_____

Facility of Records:

_____
_____

Physician Consult:

_____

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies. These changes in our office policy and practice may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies will be applied to all protected health information we maintain.

Doctor/Staff Signature_____ **Date** _____

DATE REQUESTED _____ *DATE RECEIVED* _____