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:	

Rev. 2.19

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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:

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:_____