Authorization for Release of Patient Records

I, _____, hereby authorized the release of protected health information to Advanced Chiropractic Center. I also authorized Advanced Chiropractic Center to send my health information to the providers listed in my chart. This authority includes but is not limited to patient notes, narratives, examinations, impressions and results of special testing.

In addition, I specifically authorize the release of data and information relating to: (mark the appropriate number)
1._____Substance Abuse
2._____Mental Health (including psychological testing)
3._____HIV-Related Information

This protected health information may be used or disclosed to carry out treatment, payment and/or health care operation at Advanced Chiropractic Center.

This authorization shall be in force and effect as long as copies may reside in my patient records at Advanced Chiropractic Center or until records necessitate return.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Advanced Chiropractic Center. I understand that revocation is not effective to the extent that Advanced Chiropractic Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Advanced Chiropractic Center will not condition my treatment or payment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ Date:_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative (Please Print)

_____
Description of Personal Representatives Authority