AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient's Name: ____________________ Date of Birth: ____________________

I request and authorize ______________________________

to release protected healthcare information of the patient named above to:

Name: Chester Chiropractic Office

Address: 7 Academy Avenue

City: Chester State: NY Zip Code: 10918

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

____

☐ All healthcare information

☐ Other:

____

Expiration Date of Authorization

This authorization is effective through (check one) ☐ ___/___/___ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

____
Patient Signature:

____
Date Signed:

____
Signature of Patient's Representative (if applicable)

____
Relationship to Patient