ALL HEALTH CHIROPRACTIC

24932 Aurora Rd. Suite C
Bedford Hts, OH 44146
(440) 439-9440 • Fax (440) 439-9447

27801 Euclid Ave. Suite 100
Euclid, OH 44132
(216) 289-2632 • Fax (216) 289-2654

AUTHORIZATION FOR USE AND DISCLOSURE OF RECORDS (PHI)

Name _____ Soc Sec _____ Date of Birth _____

Address _____

I Authorize:

_____

_____

_____

To Release to:

All Health Chiropractic
24932 Aurora Rd
Bedford Hts, OH 44146 • Fax (440) 439-9447

SPECIFIC DESCRIPTION OF INFORMATION (PHI) TO BE USED AND DISCLOSED

(specify dates for each, unless "entire medical record" is selected)

- ☐ Treatment from (*date*) _____ to (*date*) _____
- ☐ Entire Medical Record for all dates
- ☐ Hospital Admission Summary
- ☐ Hospital Discharge Summary
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Progress/Clinic Notes
- ☐ Other (please specify) _____

_____

- ☐ Lab Reports
- ☐ Radiology (X-ray/MRI/CT) Reports
- ☐ Radiology (X-ray/MRI/CT) Films
- ☐ EMG Reports
- ☐ Immunizations
- ☐ Psychiatric Reports

☐ Verbal discussion only - do not release any written records.

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:

☐ Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

PURPOSE OF THE USE AND DISCLOSURE

- ☐ Further Treatment (Date of Appointment _____)
- ☐ Insurance Application
- ☐ Disability Determination
- ☐ Vocational Rehabilitation Evaluation
- ☐ At my request
- ☐ Other _____
- ☐ Legal
- ☐ Personal Records
- ☐ Education
- ☐ Payment of Insurance Claims

I authorize the use and disclosure of my individual identifiable protected health information as described above. This allows my records to be verbally discussed, mailed, e-mailed, and faxed. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand this authorization will expire on _____ (12 months from the date of signing if no date or event is specified.)

A photocopy, fax or email of this authorization will be treated in the same manner as the original.

Signature of patient or representative _____ Date _____

(If not patient, state authority/relationship)_____ Identification checked. _____