REEDCHIROPRACTIC

Authorization for the Release of Protected Health Information

Patient Name:_____
SS#: _____-_____-_____
Birth Date: _____/_____/_____

Authorization

1. I, _____, hereby authorize
(Name of Patient or Patient's Legally Authorized Representative)

2. Name of physician or facility:_____

Street Address: _____

City, State, Zip Code:_____ Telephone: ( )_____

3. To release the following information
☐ Complete Record ☐ Outpatient Care ☐ Inpatient Care
☐ X-Ray Results ☐ Laboratory Results ☐ Treatment Plan Update
Other_____
If my record contains the following information, it is also released if *CHECKED* in boxes below:
☐ Substance Abuse ☐ Mental Health Treatment ☐ HIV Testing or Treatment

4. To: **Reed Chiropractic**
250 W. Baseline Rd. # 107
Tempe AZ 85283
Telephone: (480) 201-7929
Fax: (480) 222-0453

This information release is at my request for the purpose of legal assistance.

5. Signature:
I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to the office or physician named above. I understand that, if the office or physicians that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such office or physician may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This authorization expires ☐ 6 months ☐ one year from today's date, or upon the following specified event: _____.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed (Patient) _____
Relationship to Patient_____
Date: _____/_____/_____