

Authorization to Release Health Information

I hereby authorize _____ to release to the office of Dr. Scot Thomas Anderson at Integrity Chiropractic and Family Wellness, PC, and any employee of said office, copies of all information comprising the entire record, but not limited to:

final diagnosis, discharge summaries, histories, physical examinations, consultation reports, diagnostic test reports, diagnostic images, MRI's, CT's, X-rays, Films, Operative Reports, pathology reports, progress notes, physicians orders, office notes, computer entries, electronic mail, patient forms and questionnaires, medical bills, emergency room treatments, therapy notes, clinical notes, medication records, evaluations, HIV/Aids results, correspondence, complete patient file.

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), information concerning testing or treatment of AIDS and AIDS related conditions, drug or alcohol abuse, human immunodeficiency including specifically, but not limited to those records contemplated by 42 U.S.C S290 dd-2, 42 U.S.C S290 dd-3 and 42 U.S.C. s290 ee-3.

To assist in the identification and location of these records, I am providing the following information:

Name: _____
Date of Birth: _____
Social Security Number: _____

This authorization shall be in force and effect until revoked by me. I understand that this authorization is subject to revocation by me at any time by written notice to Integrity Chiropractic and Family Wellness, PC., except to the extent that you have already taken action in reliance upon it.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in C.F.R 164.254. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr. Scot Anderson at Integrity Chiropractic and Family Wellness, PC. or other individual at the organization.

By reason of the fact that the information acquired was from a physician, surgeon, or health care provider and the information is confidential to me, I am requesting you treat such information as confidential and do not furnish any confidential information, in any form, to anyone, other than the doctor listed above, without written authorization from me.

This release is intended to comply with the Health Information Portability and Accountability Act (HIPAA) and the individual forms of health care providers or health care institutions.

Patient (please print):

Witness (please print):

Patient Signature:

Witness Signature:

Date:

Date: