HEALTH & WELLNESS CLINIC

CHIROPRACTIC **WELLNESS**

M.K. Murphy, D.C.

AUTHORIZATION TO RELEASE, REQUEST OR OBTAIN CONFIDENTIAL INFORMATION

By signing this authorization, I authorize Health & Wellness Clinic to use and/or disclose certain protected health information (PHI), about me to or for the party or parties listed below.

I, ____, Date of Birth: _________________, SSN: ______________________
hereby authorize Health & Wellness Clinic to **[ ] OBTAIN [ ] RELEASE** medical information via mail, facsimile, or other appropriate source **[ ] TO [ ] FROM:**

____
(Person(s) or Entity(s) to receive / release requested information)

____
(Address) (City, State, Zip) (Phone Number) (Fax Number)

I. The individually identifiable health information to be obtained / released is: (Please place a ✓in appropriate space(s).)

____ All Medical Records / Information (reports, phone notes, testing, therapy, billing, etc. only)
____ Entire medical chart (Specify if cover to cover requested) ____ Therapy Notes
____ X-Ray, Laboratory or other Diagnostic Reports ____ Medication List(s)
____ Nursing / Phone Notes ____ Financial Information
____ Emergency Room Records from _____________________ (Dates)
____ Inpatient Records from ____________________________ (Dates)
____ Only the period of events from _________________________ to ________________________ (Dates)
____ Only information related to (specify) ____
____ Other (Specify) ____

Additional Information to obtain / release: (Please place a ✓in appropriate space(s).)
____ Psychological Records / Information ____ Drug / Substance Abuse ____ HIV results, information

- Alcohol, drug abuse information, etc. if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42CFR part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations. Additionally, further release of HIV related information is prohibited without specific authorization.

II. The purpose or need for the disclosure of information ____.

III. This authorization will expire on ______________________. (Please indicate expiration date or specific event). (If authorization not revoked, and no expiration / event noted, it will terminate 1 year from the date of signature below.)

IV. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. My written revocation must be submitted to the Health & Wellness Clinic's Privacy Officer at the address noted on this authorization.

I understand that this practice may or may not receive payment or other renumeration from a third party in exchange for using or disclosing the PHI. I further understand that the Health & Wellness Clinic may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization.

I understand that the release, use, or disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal HIPPA privacy rule.

I understand I have the right to refuse this authorization and the facility name above is released from all legal liability that may arise from the release or receipt of the information requested.

____ ________________________ ________________
(Signature of Patient or Legal Guardian) (Relationship to Patient) (Date Signed)

For Office Use Only: **FILE#:___________**
Authorization received / verified by: ______________________________ **on** _________________.
Copy of Authorization form given to patient [ ] YES [ ] NO
Authorization fulfilled and information sent: ____

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