SPINE AND SPORT CHIROPRACTIC
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Dr. Andrea Burckhard

Authorization to Release and Disclose Protected Health Information

Patient's Name: _____ Medical Record #:_____
Previous Names: _____Date of Birth: _____
Address: _____ Day Phone: _____
City: _____ State: _____Zip: _____

1. **Please release my records from:**
   Clinic/Hospital/Health Care Provider: _____
   Address: _____ Day Phone: _____
   City: _____ State: _____Zip: _____

2. **Please Release my records to:**
   Clinic/Hospital/Health Care Provider: _____
   Address: _____ Day Phone: _____
   City: _____ State: _____Zip: _____
   If releasing records to yourself, should the envelope be marked "Personal and Confidential"? ☐ *Yes* ☐ *No*

3. **These are the records I would like to release:** ☐ All pertinent records, or check all that apply below
   ☐ History and physical exam ☐ X-ray/Radiology reports ☐ Other: _____
   For condition or dates of treatment: _____(*If blank, we will release 1 year's worth of most recent records.)*
   Date records are needed by: _____ *Will records be picked up?* ☐ *Yes* ☐ *No*

4. **Purpose:**
   ☐ Continuing care ☐ Transfer of care ☐ Social security appeal
   ☐ Insurance application ☐ Personal use or review ☐ Social Security disability determination
   ☐ Insurance payment/claim ☐ Litigation/legal ☐ Other_____

5. **This authorization expires one year after I sign it, or on** _____ (write in expiration date or event).

6. **I understand the following:**

   - All records will be released to the person, clinic or organization named above. This includes details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. If I do not want these to be released, I will place a check mark here: _____ I do not want the following records released: _____
   - This authorization may be canceled in writing at any time. This will not apply to records that have already been released.
   - Once the records are released to the person, clinic or organization named above, the clinic releasing them cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws. By signing this authorization, you release Spine and Sport Chiropractic PLLC from any and all liability resulting from a re-disclosure by the recipient.
   - Spine and Sport Chiropractic PLLC will not restrict my treatment if I choose not to sign this authorization.
   - Spine and Sport Chiropractic PLLC's records may include records that it received from other organizations. If these records have been used by Spine and Sport Chiropractic PLLC and filed in the record Spine and Sport Chiropractic PLLC maintains about you, these records may be released with your Spine and Sport Chiropractic PLLC records.
   - Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Date Signature of patient or authorized person Authority to act on behalf of patient (proof required)