AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized 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 that it may be re-disclosed by the recipient.

Patient Name: ____

Organization Providing the Information: Chiropractic and Rehabilitation Center

Organization(s) or Person(s) Receiving the Information: ____________________

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Specific Description of Information Disclosed: _________________________

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Purpose of Disclosure:____

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If this Authorization is for marketing purposes, remuneration is/is not involved (Provider circle one)

Date of Services: _____/_____/_____ (DD/MM/YYYY)

You must read and initial the following statements:

1. I understand this Authorization will expire on **12/31/2099** or on the following event ________________________. Initials: _____
2. I understand that I may revoke this Authorization at any time by notifying Chiropractic and Rehabilitation Center in writing, but if I do, it will not have any effect on any actions Chiropractic and Rehabilitation Center, took before they received the revocation.

Initials: _____

______________________________ ______________________________

Signature of Patient or Representative

______________________________ Date______________________________

Relationship to Patient

You may refuse to sign this Authorization.
We cannot condition treatment on your signing this Authorization.