CLEAR CHIROPRACTIC Upper Cervical Care

2503 E 27th Ave. Spokane, WA. 99223
Phone: 509-315-8166 Fax: 509-315-8308

Records Release Authorization

Patient Name: _____ D.O.B._____
Home/ Cell Phone: _____Work Phone: _____

Hereby authorize (Facility from):_____
Address: _____
Phone: _____ Fax: _____

To: (Facility Name) _____Phone Number: _____
Address: _____Fax Number: _____

I specifically authorize the use and disclosure of the following information to Clear Chiropractic:
Chart notes: _____thru_____
Evaluation Notes/ recommendations: _____thru_____
Digital Images- X-rays (Please Mail):_____
Imaging Report**:** _____
Progress Notes: _____thru_____
Other: _____
The information for which I am requesting disclosure will be used for the following:
New Chiropractor Coordination of care Other: _____

I understand that I have the following rights:
*The information listed above is being released for the stated purpose. Any other is forbidden.
*I receive a copy (Normal fees apply)
*This authorization is voluntary and I may refuse to sign authorization form. Refusal to sign will not affect your ability to obtain treatment by Clear Chiropractic.
*This authorization is valid for 90 days. I understand that I may revoke authorization at any time. Your revocation will not apply to any release we have already made in response to this authorization.
*I may receive a copy of this Authorization if requested
*I understand that once the information listed above has been disclosed: It may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.
*I have read and understand this authorization and authorize the use and /or disclosure of health information as described in this authorization.

_____

Signature of patient or surrogate decision maker Date

_____

Print name of surrogate decision maker and relationship to patient