NORTHERN LIGHTS CHIROPRACTIC
1116 ARSENAL STREET
WATERTOWN, NY 13601
315 782-7166

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient
Name _____

Address_____

SS#_____ Date of Birth_____

[1] I authorize_____
to release protected health information from the medical records of above named patient.

[2] This information may be disclosed to and used by:

_____(Name)

_____(Address)

[3] They type and amount of information to be used or disclosed is as follows (check off the appropriate items and include other information, where indicated)

[ ] Problem list [ ] Medication list [ ] List of allergies
[ ] Most recent history and physical [ ] Most recent discharge summary
[ ] Laboratory results from_____(date) to _____(date)
[ ] X-ray and/ or imaging reports from _____(date) to _____(date)
[ ] Consultation reports from (please supply doctors' names)_____
[ ] Entire record
[ ] Other (please describe)_____
_____

[4] This information is being used or disclosed for the following purposes:

[ ] At the request of the individual
[ ] Other_____

(Although information should not be re- disclosed, it may be disbursed by another entity during routine treatment, payment or business operations and therefore would not be covered by Federal Regulations.)

[5] Unless otherwise revoked, this authorization will expire on the following date:_____
(If I fail to specify an explanation date, this authorization will expire six months from the date of signing.)

I, the undersigned have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn be me by notifying my provider in writing at any time except to the extent that action has been taken in reliance upon it. The provider is released and discharged of any liability and the undersigned will hold the provider harmless, for complying with this 'Authorization for Release of Medical Information'.

_____ _____
Signature of Patient or Parent or Legal Representative **Date**

_____ _____
Name of Parent or Legal Representative (Please Print) **Relationship/ Authority**