AUTHORIZATION FOR RELEASE/DISCLOSURE OF MEDICAL INFORMATION

Ryan Chiropractic, PLLC
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Patient Name: ______________________________ **D.O. B.** ______________

Address: ______________________________

______________________ , ______________ ____________

Phone: ______________________

This authorization allows Ryan Chiropractic, PLLC to send and receive copies of your record to (or to discuss information with) the provider/person/facility below.

NAME/ADDRESS OF PROVIDER/FACILITY: ______________________________

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DATE OF VISIT(S): ______________________________

SPECIFIC INJURY: ______________________________

Information to be released:

- ☐ Clinic/Doctor/Dentist Visit
- ☐ Radiology Report
- ☐ Physical/Occupational Therapy Record
- ☐ Laboratory Test Results Immunization
- ☐ Emergency Department Record
- ☐ Ambulatory Surgery Visit

Authorization Valid for :

- ☐ This request only
- ☐ One year from date of his authorization OR ________________ . This authorization applies to records of the treatment received on or prior to the date of this authorization.
- ☐ This request AND for medical records of any future treatment of the type described above until ________________ .

I understand that my right to healthcare is not conditioned to this authorization. I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. I the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed, except that records protected by Federal Confidentiality Rules 42 CR, Part 2 may not be disclosed without my written authorization unless otherwise provide for in the regulations. There may be a charge for the requested records, and the medical records requested above may be faxed in cases of medical necessity.

______________________________ ______________________

SIGNATURE OF REPRESENTATIVE DATE