



# Authorization to Release Medical Records

Today's Date \_\_\_\_\_

Patient (printed) Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize Charlotte Chiropractic Center, PLLC to  **OBTAIN** or  **RELEASE** requested records from the following:

Doctor Name \_\_\_\_\_ Practice Name \_\_\_\_\_

Practice Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Reason for Request:  Continued Care  Insurance  Legal Purposes  Second Opinion

Personal

Dates of Service Requested: \_\_\_\_\_ to \_\_\_\_\_

Information Requested:  X-rays  Office Notes  Entire Record

**The individual signing this form agrees and acknowledges as follows:**

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: \_\_\_/\_\_\_/\_\_\_

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient or Parent/ Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_