Coleman Chiropractic P.C.

Authorization for Release of Protected Health Information

Please read this authorization for release of protected health information carefully and fill it out completely. Failure to fully complete all sections of the authorization form will result in the authorization being invalid. Responses should be printed in the spaces provided using blue or black ink.

Patient Information

Name_____

Date of Birth_____

Authorized Representative Information

Name_____

Description of Representative's authority to act/relationship to patient_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Recipient Information

I authorize the following individual or entity to receive the protected health information regarding the patient listed above.

Name_____

Address_____

Phone_____Fax_____

Information to be disclosed and purpose

This authorization is limited to the following protected health information and the following purposes or discloser:

- All records including but not limited to all chart entries, diagnosis, test results, reports & bills.
- Only records relating to the following dates of service_____
- Only records relating to the following diagnosis_____

Purpose of Use or Discloser:_____

Signing this form means that you understand and agree to the following:

- You understand that this authorization is good for a period of (1) year from the date you sign it. The authorization will expire after that time period.
- You understand that you may revoke this authorization at any time by notifying Coleman Chiropractic P.C. in writing at: 605 N. Commercial Ave, St. Clair, MO 63077. If the authorization is revoked it will not have any effect on disclosers that were made before you notification revoking this authorization was received by recipient.
- You understand that upon request you may receive a paper copy of this authorization at anytime.
- You authorize Coleman Chiropractic P.C. to disclose protected health information about the patient listed above.

Signature of Patient_____Date_____

Printed Name_____

Signature of Authorized Representative_____

Relationship to Patient_____Date_____