## Brook West Chiropractic Clinic

## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, ________________________________ [Name of Individual], authorize _________________________________ to release my Protected Health Information, as described below, to:

| **RELEASE TO / FROM:** | **CLINIC ADDRESS TO / FROM :** |
|---|---|
| Brook West Chiropractic Clinic | ____________________________________________ |
| Name of Health Care Provider/Plan/Other | Name of Health Care Provider/Plan/Other |
| 6800 78th Ave N Suite 107 | ____________________________________________ |
| Street Address | Street Address |
| Brooklyn Park, MN 55445 (763) 566-1042 | ____________________________________________ |
| City, State, Zip Code | City, State, Zip Code |

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

___ Complete Medical Record ___ Medical History, Evaluation Records ___ Immunizations
___ Treatment or Tests ___ Hospital Records Including Reports ___ Surgical Reports
___ X-ray Films ___ Laboratory Reports ___ MRI Reports
___ Consultation Documentation
___ Other (Specify):___________________________________________________________________________________

I also specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY): ___ HIV/AIDS, ___Substance Abuse (alcoholism or drug abuse), or ___Mental Health be released to the above referenced recipients.

It is my understanding that the information to be released will be used for the following purposes (CHECK ALL THAT APPLY):

___ At the request of the individual (no purpose need be specified) ___ Additional Medical Care
___ Insurance Eligiblity/Benefits ___ Change of Provider ___ Legal Investigation or Action
___ Other (Specify): ___________________________________________________________________________________

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed by the recipient without obtaining any further authorization.

**INDIVIDUAL’S RIGHTS RELATING TO THIS AUTHORIZATON:**

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact: Chad Clementson at (763) 566-1042. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

**EXPIRATION DATE:** This Authorization is valid for one (1) year from the date I signed this form.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

**INDIVIDUAL’S SIGNATURE:** **Representative’s signature: (if applicable)**

_____________________________________________ _____________________________________________

**INDIVIDUAL’S PRINTED NAME:** **Description of representative’s relationship:**

_____________________________________________ _____________________________________________

**DATE OF BIRTH:** _____________________ **DATE:** _______________