

**HEALING**

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**1132 Arcade Street St. Paul, MN 55106 Phone: 763-458-6804 Fax: 651-771-4204**

**Authorization for Release of Medical Information**

**TO RELEASE MEDICAL RECORDS FROM:**

**Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REGARDING THE FOLLOWING PATIENT:**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female SSN#: \_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_\_**

**Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RECORDS TO BE RELEASED:**

\_\_\_ Consultation Report \_\_\_ Pathology Report \_\_\_ X-ray Report/X-ray Films

\_\_\_ Emergency Report \_\_\_ History & Physical \_\_\_ All Lab Report(s)

\_\_\_ Radiology Report \_\_\_ Forms/Questionnaires \_\_\_ EMG Report

\_\_\_ Complete Medical Records \_\_\_ RE: Motor Vehicle Accident \_\_\_ Work Comp. Accident

DOT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOT: \_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE OF RELEASE (please check):**

\_\_\_ Continuing Care \_\_\_ Insurance Claims \_\_\_ Litigation \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO WHOM RECORDS SHALL BE RELEASED (AUTHORIZED RECIPIENT):**

**Healing Chiro Center, PLLC**

**1132 Arcade St.**

**St. Paul, MN 55106**

**Revocation/Expiration:**

I hereby authorize and understand that this authorization will be in effect for 36 months from the date of this authorization, unless revoked by me in writing at any time. I may revoke this authorization by filling out the revocation form provided by Healing Chiro Center, PLLC or by writing a letter that I want to revoke this authorization. The revocation will take effect as soon as the facility receives my notice in writing. I understand that my revocation does and will not affect the records that have already been released.

**Authorization:**

I understand and authorize the above named facility to furnish the office of Healing Chiro Center, PLLC with the information requested. I understand that treatment, payment, enrollment or eligibility of benefit may not be conditioned on obtaining my signature on this authorization.

\*I do not authorize the release of any of my information to any third party. I understand that once my information is released as specified in this authorization form, the facility, their employees and physician(s) will prevent the re-disclosure of the information.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness/Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_