AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ DOB:_____

MRN: _____

I hereby authorize _____ to release a copy of my medical record, or a portion as specified below, for the purpose of continued care and treatment to:

Dr. Michael T. Ryan III
Ryan Chiropractic, PC
9 Nahant Street Lynn, MA 01902
Phone (781) 595-6560 Fax (781) 595-6580

Please send this information via FAX to 781-595-6580

The specific information to be released is for the dates _____ - _____ includes:

_____ complete medical record _____ lab test results _____ ER visit

_____ x-rays / radiology reports _____ MRI / CT

_____ other (specify) _____

Please INITIAL to indicate if you give permission to release the following information if present in your record

_____ Yes HIV Tests & Related Information
_____ Yes Genetic Screening Test Results
_____ Yes Hepatitis B and C, STDs, Abortion, OB/GYN
_____ Yes Details of Domestic Violence Victim's Counseling
_____ Yes Details of Sexual Assault Counseling
_____ Yes Alcohol and/or Substance Abuse
_____ Yes Psychiatric Treatment Notes
_____ Yes Confidential communications with a Licensed Social Worker

This authorization will remain in effect for 1 year from the date below or as specified: _____. I understand that I may revoke this authorization at any time by providing the medical record department correspondence section with a written revocation, and that the revocation will be honored except to the extent that this authorization has been acted upon. I also understand that the recipient may redisclose this information if the recipient is not required to follow privacy regulations of statutes. Treatment or payment is not affected if this authorization is not signed.

_____ _____
Signature of patient / legally recognized representative Date

_____
Relationship to patient of legally recognized representative, if signed by such person