Authorization to Release Medical Records

Clayton, NC 919-585-4885 info@align.family

Patient (printed) Name _____
Date of Birth _____

I hereby authorize Align Family Chiropractic PC 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 disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient or Parent/ Legal Guardian Signature_____
Date _____