Authorization for Release of Information

IMPORTANT: All Areas **BOLD** must be completed

Patient Last Name | **First Name** | **MI** | **Date of Birth**

Patient Address (PO Box/Street) | **Social Security Number**

City | **State** | **Zip** | **Daytime Telephone Number**

I Authorize:

W Chiropractic Incorporated
Dr. Mark Wilson
2801 Great Northern Loop
Missoula, MT 59808
406-549-9100
406-549-9151

Outside Facility: (Complete Information Below)

Health Care Provider Name

Address

City/State/Zip

Telephone/Fax Number

To:

Information to be released/r ☐ **Release** ☐ **Receive**

All Medical Records
Only Medical Records from
Only Dates of Service from
Information from medical record for the completion of a disability from
X-ray Films
Other

Send the information to:

Address:

Fax Information Yes/No **Fax Number**

Purpose of Disclosure:

The medical record includes all health care information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in your/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status and/or diagnosis AIDS and/or other sexually transmitted diseases including hepatitis.

If one of the above facilities is requesting this authorization be completed, an individual has the right not to sign with the understanding that an individual's health care and the payment for health care will not be affected.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to W Chiropractic Incorporated, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be redisclosed by the recipient and no longer be protected under federal law.

Patient Signature (if over 18) **Date** **Expiration Date**

or

Legal Representative/Guardian **Date** **Relationship to the patient**