



GOFFSTOWN CHIROPRACTIC CARE, PLLC

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Goffstown Chiropractic Care, PLLC and any of its appointed assistants to disclose the following information from the healthcare record of:

Patient Name _____ Date of Birth _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

This information is to be disclosed to:

Agency/Business Name _____ Contact Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

For the purpose of (please check one):

- Moving
- Changing provider
- At the request of the individual
- Consultation
- Insurance change
- Other (please describe) _____

Information to be disclosed:

- Office notes for date(s) of service _____
- X-ray reports of _____ for date(s) of service _____
- MRI reports of _____ for date(s) of service _____
- CD(s) containing images of above marked studies
- Photographs or other images
- Complete healthcare record
- Other (please describe) _____

Special instructions: _____

I Understand that:

- Treatment will not be conditional on whether I sign this Authorization.
- This Authorization is voluntary and I have the right to refuse to sign it.
- This Authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date).
- If I sign this Authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice. Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the Authorization.
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
- Once signed, the Practice will provide me with a copy of this Authorization.

Signature of patient/guardian

Date

Printed name of patient/guardian