

**Capitol Chiropractic Health Center**

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

I, \_\_\_\_\_ [Name of Individual], authorize Capitol Chiropractic Health Center to release my Protected Health Information, as described below, to:

**RECIPIENT(S) INFORMATION:**

_____ Name of Health Care Provider/Plan/Other	_____ Name of Health Care Provider/Plan/Other
_____ Street Address	_____ Street Address
_____ City, State, Zip Code	_____ City, State, Zip Code

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Medical History, Evaluation Records	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Treatment or Tests	<input type="checkbox"/> Hospital Records Including Reports	<input type="checkbox"/> X-ray Reports
<input type="checkbox"/> Allergy Records	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Prescription Data
<input type="checkbox"/> Consultation Documentation	<input type="checkbox"/> Surgical Reports	
<input type="checkbox"/> Other (Specify): _____		

I also specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY):  HIV/AIDS,  Substance Abuse (alcoholism or drug abuse), or  Mental Health be released to the above referenced recipients.

It is my understanding that the information to be released will be used for the following purposes (CHECK ALL THAT APPLY):

<input type="checkbox"/> At the request of the individual (no purpose need be specified)	<input type="checkbox"/> Additional Medical Care
<input type="checkbox"/> Insurance Eligibility/Benefits	<input type="checkbox"/> Change of Provider
<input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> Legal Investigation or Action

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may then be disclosed by the recipient without obtaining any further authorization.

**INDIVIDUAL’S RIGHTS RELATING TO THIS AUTHORIZATION:**

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact: Dr. Michelle Oliver at (217) 391-5446. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

**EXPIRATION DATE:** This Authorization is valid until \_\_\_\_\_.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
Name of Patient or Legal Representative (Printed)

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Description of Legal Representative’s Relationship

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date (This authorization is valid as of the date signed above)