Cochran Chiropractic

Phone: (228) 875-3555 Fax: (228) 818-2934

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's full name at the time of treatment:_____

Date of Birth:___/____/_____ Social Security Number:_____

I hereby authorize Cochran Chiropractic to **request** or **disclose** my protected health information as indicated below to:

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Information to be released:

_____ From & To dates _____
_____ History & Physical exam _____
_____ Lab Report _____
_____ X-Ray report _____
_____ Consultation Report_____
_____ Other_____

Purpose of Disclosure:

_____ Changing Physicians
_____ Continuing Care
_____ At my (patients) Request
_____ Worker's Compensation
_____ Second Opinion
_____ Legal or Insurance

* I understand that this authorization will expire one year form my last date of service. A photocopy of this form will be considered as a valid as the original.
* I understand that I may revoke this authorization at any time be notifying the Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
* I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations. However, other state and federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information and psychiatric/mental health information.
* My health care and payment for my health care will not be affected if I do not sign this form.
* I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
* I understand that I will get a copy of this form after I sign it.

Signed:_____Date_____

Witness:_____

Proof of identification shown:_____

I Authorize _____ to pick up these records on my behalf.

If Patient is a minor,_____years of age, and I, the undersigned, am the parent or legal guardian of the patient and do hereby consent for the patient.

Signed:_____ Witness: _____
(Parent or Legal Guardian)