CARR CHIROPRACTIC CLINICS, PC

PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name ____ Date of Birth: __________________

Address ____Phone Number ____________________________

I request and authorize **to use and/or disclose my:**

☒ **Protected Health Information (PHI)**: PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services

☒ **Sensitive Protected Health Information (SPHI)**: SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

I authorize disclosure of the following information from my medical record:

___Doctor/Clinic Notes ___Laboratory Reports ___X-Ray Reports

Release records to: **Carr Chiropractic Clinics, PC**

2065 Campbell Dr

Huron, SD 57350

Fax 605-352-9776

Purpose(s) for the release:

Note: If the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose.

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I Understand that:

- Treatment will not be conditional on whether I sign this Authorization.
- This Authorization is voluntary and that I have the right to refuse to sign it.
- 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.

- This authorization will expire on ____/___/___ OR when the following event occurs:
- 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.
- This authorization CANNOT be used to disclose Psychotherapy Notes.
- Once signed, the Practice will provide me with a copy of this Authorization.
- I understand that the Practice will provide me with a copy of this Authorization once signed by me.

Signature(s)

Patient signature ____ Date ______________________

Sign below if you are a personal representative of the patient.

Representative signature_____________________________________ Date ___________________________

Print Name____ Relationship to Patient __________________