PROACTIVE CHIROPRACTIC
& LASER CENTER

HIPAA-COMPLIANT
AUTHORIZATION TO RELEASE PATIENT INFORMATION
PURSUANT TO 45 C.F.R. §164.508

Patient's Full Name: _____ Date:_____

Patient SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____

I authorize the following organization, individual, or entity to disclose protected health information identified below:

Name:_____

Address:_____

Phone #: _____ Fax #: _____

Information Requested: The Patient identified above authorizes the disclosure of all protected medical information in any form (including oral, written and electronic) to the Requestors listed below, and Requestors' re-disclosure of the data and information to its agents, consultants, counsel, and whomever Requestors deems reasonable and necessary to further the administration of the Requestor's suggested treatment and care of the Patient. Patient expressly requests that all covered entities under HIPAA identified above shall disclose full and complete protected health information concerning the Patient, relating to the time period beginning on _____ and ending on _____, inclusive. This includes, but is not limited to, the following:

- All medical records, including, but not limited to: inpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, examination reports, office and doctor's handwritten notes, and records received from other physicians or health care providers
- All laboratory, histology, cystology, pathology, radiology, CT scan, MRI, echocardiogram reports
- All radiology films
- All pharmacy prescription records.

The Patient hereby authorizes the above information be released or disclosed to:

ProActive Chiropractic & Laser Center
2535 Bethany Road, Suite 100
Sycamore, IL 60178

Ph. (815) 517-0826
Fax: (815) 517-0826

I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I understand that, after information is released under this authorization, it may be re-disclosed by the recipient, and if re-disclosed, the information will no longer be protected by federal or state privacy rules.
- I understand that I am entitled to receive a copy of this authorization.
- My treatment, payment for treatment and enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization.
- This authorization will expire one (1) year from the date signed below.

Patient's Signature: _____ Date:_____

Witness: _____ Date:_____