Gray Chiropractic Center
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Authorization for Release of Patient Information

Patient Name_____ Date of Birth_____

I hereby authorize _____
Name Mailing Address City State Zip
Telephone Number_____

to disclose the above named individual's health information as described below:

Date(s) of Service Requested (if known) or Provider:

Description of Information to be released: (check all that apply)
___Most recent history and physical
___Laboratory reports
___Radiology/Imaging reports
___Radiology films
___Consultations
___Progress notes
___Entire medical record
_____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used the following individual or organization:

_____
Name Address City State Zip

Telephone Number_____

Description of the purpose of the use and/or disclosure:

___Continuing Care
___Consultation
___Legal purposes
___Second Opinion
___Insurance
___Personal Use
___Social Security/Disability
___Other: Please describe:_____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand The Gray Chiropractic Center may charge a processing fee for this service. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event).

I understand I may revoke this authorization at any time by notifying the Gray Chiropractic Center. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed name of Patient or Patient's Representative

_____ _____
Relationship to Patient or Legal Authority (attach supporting documentation)