City Fit
Family Chiropractic Center LLC

Authorization for Disclosure of Medical Information

I hereby voluntarily authorize the use and/or disclosure of my health information, as described below, to the requestor. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the information may be further disclosed and no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by given written notice to the provider. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the provider. I understand that I may receive a copy of this form. A photocopy of this authorization is as effective and valid as the original.

PATIENT INFORMATION

Name _____

Date of birth_____ ID number (if applicable) _____

Previous Name(s) used_____

PROVIDER (Who is releasing the information)

☑ All Physicians

☑ All Hospitals

☑ All Other Health Care Providers, or Health Insurance Companies who have provided treatment, care or benefits to the above named patient

☑ Specific Provider _____

I specifically authorize Requestor to insert the names of additional specific Providers, when necessary, to facilitate the purpose of this disclosure

REQUESTOR (Where do you want the information sent)

Name **City Fit Family Chiropractic Center LLC**

Address **319 SW Washington, Suite 1001**

Portland, OR 97204

fax 503-248-5626 phone 503-224-5010

INFORMATION REQUESTED

☑ Complete records in possession of Provider and/or Its Agent

Specific information (Please specify)_____

PURPOSE OF DISCLOSURE

☐ At request of patient or legal representative

☑ Review and coordinate care in office

☐ Other_____

Doctors, hospitals and other covered entities under federal privacy regulations may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. As part of this authorization for the release of medical records, I specifically authorize the release of data and information relating to substance abuse treatment (alcohol/drug), mental health (includes psychological testing), HIV-related information (AIDS related testing) and sexually transmitted disease.

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Signature of Patient or Legal Representative Date