FAX SIGNED FORM TO: 786-235-8593 OR EMAIL TO: records@chiromedichealth.com

Chiromedic Family Practice d/b/a South Miami Chiropractic
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Miami, Fl 33143
Tel. 305-971-0302

Authorization for Use, Disclosure, and Release of Health Information

Patient Name: _____ Date of Birth: _____ SS # _____
I hereby authorize: To Release Information to: Chiromedic Family Practice, LLC.
(Name and address of releasing facility) (Individual name, facility/organization and address)
_____ _____
_____ _____
_____ _____
PURPOSE OF DISCLOSURE:

☑ Continuing Care	☑ Worker's Compensation
☑ Payment of Claim	☑ Legal
☑ School	☑ For Personal Use
	☑ Other (specify):

INFORMATION TO BE RELEASED: Between Dates of: _____ to _____

☐ Progress Notes/Provider Notes
☐ MRI/X-rays
☐ Consultation Notes
☐ Prescriptions
☐ Entire Record (excluding special permission records if initialed in above box).

ACKNOWLEDGEMENT OF UNDERSTANDING:
☐ I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
☐ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
☐ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
☐ I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
☐ I understand that SMS may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
☐ I understand that a photocopy or fax of this form is the same as the original.

_____ _____
Patient Signature Date

If I am signing as Authorized Representative of the patient, I am:
( ) Parent of minor ( ) Court appointed guarding/conservator

_____ _____
Signature of Authorized Person Relationship to Patient

_____ _____
Witness Date