Advanced Health Clinic, LLC

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name: ______________________________________ Date of Birth: ________________________

Address:____

Social Security #:_________________________________Telephone: (______)_____________________

Information To Be Released – Covering the Periods of Health Care
From (date) _______________________________ to (date) _____________________________________

Please check type of information to be released:

Complete health record	Chiropractic Notes
Health History	Massage Therapy Notes
Laboratory test results	Counseling Notes
Client Assessment Notes (Nursing)	Complete billing record

Other (specify)
____

Purpose of Request

Treatment or consultation	At the request of the patient	Billing or claims payment

Other (specify)
____

Who and Where to Send / Release Information

Name: ____ ______

Address:____

I understand that if my medical or billing records contain information in reference to counseling services, I have been afforded the opportunity to sign a specific authorization. ***Initial One:* Yes______ No_______**

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Advanced Health Clinic. Unless revoked, this authorization will expire on the following date or event ____or 180 days from the date of signature.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I do not have to sign this authorization, and my treatment will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or receive a copy of the protected health information to be used or disclosed.

I authorize Advanced Health Clinic to release the protected health information specified above. I further understand there is a copy fee of 10 cents/page. I understand that I am responsible for this fee.

Signature: ____ Date: __________________________

Authority to Sign if not patient:
____