Authorization to Use and Disclose Healthcare Information

Name _____ ID#/DOB _____ Date _____

I: _____, authorize my manual therapist: _____, to disclose my healthcare information with the following healthcare providers and/or insurance companies:

Name(s): _____

Address: _____

The following information may be disclosed (check all that apply):

☐ All healthcare information in my medical chart.

☐ Only healthcare information relating to the following injury, illness, or treatment: _____

_____

☐ Only healthcare information for the following dates or time periods: _____

_____

☐ Including information regarding HIV, STD, mental health, drug or alcohol abuse.

I give my authorization to release healthcare information for the following purposes (check all that apply):

☐ To share information with my healthcare team in an attempt to coordinate care

☐ To obtain payment of care expenses I have incurred for my treatments.

☐ To take part in research

☐ Other: _____

This authorization expires on:

Date: _____ (no longer than 90 days from the date signed)

Event: _____

I understand that I may refuse to sign this authorization.

I may also revoke this authorization at any time by writing a letter to my manual therapist.

I understand that once my healthcare information is disclosed, the recipient may redisclose the information and it may no longer be protected HIPAA or state privacy laws.

I also understand my obtaining care can not be conditioned on my signing this release.

Signature _____ Date _____