Larson Chiropractic/Back in Action
1001 E. Bogard Rd. Wasilla, AK 99654
Phone #: (907)376-2225 or 373-7246; Fax: (907)376-9225

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

The PHI (Personal Health Information) in this request is ***HIGHLY CONFIDENTIAL.*** It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific health care services to this patient. Any other use is a violation of the HIPAA Federal Law.

The preparation of records going to another health care provider must be asked for in writing and may take up to 3 business days to complete. We are unable to accommodate last minute requests, so please plan to allow us time to get records copied and delivered appropriately. Our office policy allows only direct transfer of original x-rays to another healthcare provider, not to the patient, on a 30 days loan basis. Details regarding the healthcare provider name, address, phone and fax must be supplied to us by the patient.

I understand I may refuse to sign this authorization. I need not sign this form to assure treatment. I also understand I have the right to revoke this authorization at any time, but must do so in writing to the attention of the Medical Records Department. This will not apply to information that has already been released as a result of this authorization. I understand the cancellation of this authorization will not apply to my insurance company, when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked or specified below, this authorization will automatically expire six months from the date it was filled out.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may no longer be protected by federal confidentiality rules.

ALL X-RAYS ARE THE PROPERTY OF THE ORIGINATING FACILITY.

I hereby authorize the release of the health records:

_______ Medical Chart notes
_______ X-rays: ______________________
_______ MRI / MRI report
_______ other: ______________________

TO/FROM: (circle one)

Larson Chiropractic/Back in Action
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(907) 376-2225

TO/FROM: (circle one)

Doctor/Hospital: ____

Address: ____

____

City State Zip Code Phone #/Fax #

____

Print Name Date of Birth Phone #

______________________________ __________
Signature of Patient/Legal Representative Date

______________________________ __________
Relationship if other than Patient Exp. Auth.

	DATE	INITIALS
Request Rec'd	______	______
Records OK'D	______	______
X-Rays Cleaned	______	______
X-Rays Viewed	______	______
X-Ray Rpt. in Chart	______	______
Records Copied	______	______

H/C_____ **Mail**_____ **Fax**_____ **Courier**_____