Mankato Chiropractic Center and Mankato's Healing Touch

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____ [Print Name of Individual] Date of Birth:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip: _____

Hereby Authorize: (below)

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

to Disclose Medical Information to: (below)

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

___ Complete Medical Record
___ Treatment or Tests
___ Allergy Records
___ Consultation Documentation
___ Medical History, Evaluation Records
___ Hospital Records Including Reports
___ Laboratory Reports
___ Surgical Reports
___ Immunizations
___ X-ray Reports
___ Prescription Data
___ Other (Specify):_____

I also specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY): ___ HIV/AIDS, ___Substance Abuse (alcoholism or drug abuse), or ___Mental Health be released to the above referenced recipients.

It is my understanding that the information to be released will be used for the following purposes (CHECK ALL THAT APPLY):

___ At the request of the individual (no purpose need be specified)
___ Insurance Eligiblity/Benefits
___ Change of Provider
___ Additional Medical Care
___ Legal Investigation or Action
___ Other (Specify): _____

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed by the recipient without obtaining any further authorization.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact: Melanie Esser at (507) 345-4035. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until _____.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

INDIVIDUAL'S SIGNATURE:

_____

DATE: _____

REPRESENTATIVE'S SIGNATURE (IF APPLICABLE):

_____

DESCRIPTION OF REPRESENTATIVE'S RELATIONSHIP:

_____