Authorization for Use and Disclosure of Protected Health Information

I hereby authorize **Adkins Chiropractic PC, 12570 Old Seward Hwy Unit 101, Anchorage AK 99515**, to disclose my protected health information to:

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I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE.**
2) I have the right to have a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization. (if allowed by State and Federal Law. See 45 CFR § 164.524)
3) I may revoke this authorization at any time by notifying **ADKINS CHIROPRACTICPC** in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was or actions taken in reliance thereon, or if the Authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) **ADKINS CHIROPRACTIC PC** agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to release the information is not a health plan, health care clearinghouse or health care provider, Federal Law (HIPPA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may be no longer protected by HIPPA rules.

TYPE OF INFORMATION TO BE DISCLOSED:

☐ Entire Medical Record

☐ Office Chart Notes

☐ Billing Statements

☐ Laboratory Reports

☐ Discharge Summary

☐ Most Recent 5 Year History

☐ All Hospital Records

☐ History and Physical Exam

☐ Emergency/Urgent Care Records

☐ Medical Record for Continuity for Care

☐ Diagnostic Imaging Reports

☐ Emergency Room Reports

☐ Radiology Reports

☐ Operative Reports

☐ Other ____________________
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EXPIRATION:
This authorization will expire 180 days from the date of signing or (insert date) ________________________

Patient Name:____ PT DOB:___________________________

____ ______________________
Signature of Patient or Legal Representative Date

____ ______________________
Printed Name of Representative (if applicable) Relation

____ ______________________
Signature of Witness Date