chirotrendz
family chiropractic and wellness center
keeping things in motion

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize ChiroTrendz Family Chiropractic and Wellness Care and any of its appointed assistants to obtain or share the following information from my healthcare record.

Patient Name ___________________________________ Date of Birth _________ Phone Number _____________________

Street Address ___________________________________ City ________________________ State ______ Zip __________

This information is to be shared with or obtained from:

CHIROTRENDZ FAMILY CHIROPRACTIC AND WELLNESS CENTER

22711 S. ELLSWORTH RD, STE 106, QUEEN CREEK, AZ 85142

OFFICE: (480) 264-6800 **FAX:** (480) 300-4688 www.ChiroTrendz.com info@ChiroTrendz.com

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I authorize the following entity to share or obtain all or portion of my healthcare record:

Agency/Business Name ____ Contact Name (if applicable) _____________

Street Address ___________________________________ City ________________________ State ______ Zip __________

Phone Number ___________________________________ Fax Number ____

For the purpose of:

❑ Changing provider ❑ Consultation ❑ Chiropractic treatment ❑ At the request of the individual

❑ Other (please describe) ____

Information to be disclosed:

❑ Office notes for date(s) of service ____

❑ X-ray reports of __________________________________for date(s) of service _____________________

❑ MRI reports of ___________________________________for date(s) of service _____________________

❑ CT scan reports of ________________________________for date(s) of service _____________________

❑ Complete healthcare record

❑ CD(s) containing images of above marked studies

❑ Other (please describe) ____

I understand that treatment will not be conditional on whether I sign this Authorization and that this Authorization is voluntary and I have the right to refuse to sign it. I further understand that this Authorization will remain in effect for one year from the date of the signature below, unless I specify a different date here: ___________. I understand that if I sign this Authorization, I may revoke it later by sending a written notice of revocation to the privacy officer at ChiroTrendz LLC. Note: The only exception to my right to revoke is if ChiroTrendz LLC has already acted in reliance upon the Authorization. The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws. Once signed, I understand that I will be provided with a copy of this Authorization.

____ _________________________

Signature of patient/guardian Date

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Printed name of patient/guardian

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