RAPP CHIROPRACTIC

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

The Following Information is Strictly Confidential

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____

to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ Other: _____

☐ Purpose: _____

I understand the following:

- Except for psychotherapy notes (which are not included in my medical record), all records will be released to the person, clinic or organization named above. This includes details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV.
- If I don't want these to be released, I will place a check mark here: _____. I do not want the following records released: _____.
- If I change my mind, I may write to the address in section 1 to stop the release of my records. This will not apply if the form expires one year after I sign it, or on (date :_____).
- There may be a fee for releasing these records.
- Once the records are released to the person, clinic, or organization named above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
- To be valid, this form must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this form, I will still be treated, unless treatment is part of a research project.

Patient Signature: _____ Date Signed: _____