AUTHORIZATION FOR RELEASE OF INFORMATION

PROTECTED HEALTH INFORMATION – ("PHI") under HIPAA is defined as information that is received from, or created or received on behalf of _____ and is information about an individual which relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and that identifies to the individual, or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased. The following components of a patient's information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a patient, including birth date, admission date, discharge date and date of death; d) telephone numbers, fax numbers and electronic mail addresses; e) Social Security numbers; f) medical records numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate / license numbers; j) vehicle identifiers and serial numbers including license plate numbers; k) devise identifiers and serial numbers; l) Web Universal Resource Locators (URL's); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic or code.

I, _____, the undersigned, hereby authorize Adjustin Chiropractic to release the following information from my medical record. This Authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and / or psychiatric / psychological conditions.

The following information may be released or reviewed:

(X) Inpatient		(X) Emergency Room		(X) Outpatient		(X) Any and all
X	FACE SHEET			X	TEST RESULTS	
X	CASE SUMMARY			X	CONSULTATIONS	
X	DISCHARGE SUMMARY			X	OUTPATIENT CLINIC NOTES	
X	HISTORY & PHYSICAL EXAMINATION			X	IMMUNIZATION RECORDS	
X	OPERATIVE AND PATHOLOGY REPORT			X	DOCTOR'S ORDERS	
X	EMERGENCY DEPARTMENT RECORD			X	PROGRESS REPORTS	
X	NURSING NOTES			X	OTHER _____	
X	X-RAY FILM			X	ITEMIZED BILLING STATEMENTS	

Date(s) of treatment: ALL

The above information may be released to any parties involved directly or indirectly in my claim, treatment, or case.

Revocation: I understand that I may revoke this Authorization at any time by notifying Adjustin Chiropractic in writing by sending a letter to the Office Manager at 4440 Broadway, Suite 12, Quincy, IL 62305. I understand that if I revoke this Authorization, it will not affect any actions that Adjustin Chiropractic took before it received my revocation letter.

Term: This authorization is to remain in full effect until I provide Adjustin Chiropractic with a signed and dated written notice.

Re-disclosure: I understand that the information used and / or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

_____
WITNESS

_____
DATE

_____
SIGNATURE

_____
DATE

_____
SOCIAL SECURITY NUMBER

_____
DATE OF BIRTH