STRATEGIC HEALTH
CHIROPRACTIC

Authorization to Release Health Care Information
(Records *Coming In*)

Patient's Name _____ DOB _____

Previous name _____ DL# _____

TO: _____

_____ P: _____
(Name of provider)

_____ **F:** _____
(Address)

_____

I request and authorize you to release health care information of the patient named above to:

Dr. Stephen C. Chan/ Strategic Health Chiropractic
1200 112th Ave. NE, Suite C180/ Bellevue, WA 98004
425.467.5955 FAX: 425.467.5839

This request applies to:
- ☐ All records
- ☐ Imaging and reports (x-ray, MRI, CT, other)
- ☐ Other: _____

From _____ to _____
Date Date

My Rights:
I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third part. I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand that once healthcare information is disclosed, the person or organization my re-disclose it. Privacy laws may no longer protect it.

***EXCLUDE** the following information from the records released (please initial):

_____ Drug/ alcohol abuse/ treatment & diagnosis
_____ HIV/ AIDS diagnosis/ treatment/ testing
_____ Sexually Transmitted Disease
_____ Mental Illness or Psychiatric diagnosis/ treatment

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/ or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/ mental health or drugs and/ or alcohol use. Unless excluded above, if I have been tested diagnosed, or treated for HIV (AIDS virus), STD's, psychiatric disorders/ mental health, or drug and/ or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment.

_____ _____
Signature of patient's authorized representative Date

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED