



**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

I, \_\_\_\_\_, \_\_\_\_\_  
[Name of Patient] [Date of Birth]

authorize **Palmer Chiropractic Clinics** to release my Protected Health Information to:

Please check one if releasing to yourself: \_\_\_\_\_  
Name of Health Care Provider/Plan/Other  
 Mail Records (provide address) \_\_\_\_\_  
Street Address  
 Pick Up Records \_\_\_\_\_  
City, State, Zip Code

To release and/or discuss the following information:  Complete Records  X-Ray Images Only from date: \_\_\_\_\_  
 X-Ray Report Only from date: \_\_\_\_\_  X-Ray Images & Report from date: \_\_\_\_\_  Other: \_\_\_\_\_

I specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY): \_\_\_ HIV/AIDS, \_\_\_ Substance Abuse (alcoholism or drug abuse), or \_\_\_ Mental Health be released to the above referenced recipients.

I understand that if the authorized recipient is not a healthcare provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed by the recipient without obtaining any further authorization.

This authorization is granted for the following purpose: \_\_\_\_\_

**PATIENT’S RIGHTS RELATING TO THIS AUTHORIZATION:**

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact the Privacy Officer at (563) 884-5701. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

**EXPIRATION DATE:** This authorization expires \_\_\_\_\_ 6 months \_\_\_\_\_ one year from today’s date, or upon the following specified event: \_\_\_\_\_.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
**PATIENT’S SIGNATURE:**

\_\_\_\_\_  
**REPRESENTATIVE’S SIGNATURE (IF APPLICABLE):**

\_\_\_\_\_  
**DATE:**

\_\_\_\_\_  
**DESCRIPTION OF REPRESENTATIVE’S RELATIONSHIP:**

**Office Use Only**  
Date Completed \_\_\_\_\_  
Initials \_\_\_\_\_

Signature for Pick Up: \_\_\_\_\_  
Date: \_\_\_\_\_