SCHARENBERG CHIROPRACTIC
421 N WEBB RD
WICHITA, KS 67206
316-945-0075

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I,_____ (Name of Individual) authorize the release of my Protected Health Information to Scharenberg Chiropractic Offices.

PROVIDER INFORMATION:

_____
Name of Health Care/Plan Provider

_____
Phone Number

_____
Street Address

_____
City, State, Zip Code

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

___ Complete Medical Record ___Medical History, Evaluation Records ___ Immunizations
___ Treatment or Tests ___Hospital Records Including Reports ___ X-ray Reports
___ Allergy Records ___ Laboratory Reports ___ Prescription Data
___Consultation Documentation ___ Surgical Reports ___X-Rays
___Other(Specify):_____

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

It is my understanding that the information to be released will be used for the following purposes (CHECK ALL THAT APPLY):

___ At the request of the individual (no purpose need be specified) ___ Additional Medical Care
___ Insurance Eligibility/ Benefits ___ Legal Investigation or Action
___ Change of Provider ___Other(Specify):_____

I understand that if the authorized recipient is not a provider, health plan, or clearing house 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.

INDIVIDUAL'S RIGHT RELATING TO THIS AUTHORIZATION:

I understand that I must be provided with a copy of this form if I chose to sign it. I understand I am under no obligation to sign this form and 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 Phyllis Scharenberg at (316) 945-0075. 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 organizations listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until_____(Expiration Date).

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.

INDIVIDUAL'S SIGNATURE:

_____

SS # _____

BIRTHDATE _____

DATE: _____

REPRESENTATIVE'S SIGNATURE (IF APPLICABLE):

_____

DESCRIPTION OF REPRESENTATIVE'S RELATIONSHIP:

_____