ROSENBLUM CHIROPRACTIC, LLP
Phone: (518) 946-7886
Fax: (518) 730-0228
info@chiroinjay.com

AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name: _____ Phone: ( )_____

Date of Birth: _____ Email: _____

1. I authorize the disclosure of the above-named individual's health information as described below:

2. **Rosenblum Chiropractic, LLP** is authorized to make the disclosure:

3. The type and amount of information to be used or disclosed is as follows:
(Check appropriate boxes)

- ☐ Entire record
- ☐ Specific records (describe) _____
- ☐ All dates
- ☐ Date Range From:_____ to _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

   a. This information may be disclosed to and used by the following individual or organization:

   RECORDS CAN ONLY BE TRANSMITTED ELECTRONICALLY VIA EMAIL OR FAX

   Name of party to release records to: _____
   email address: _____ or Fax# (___)_____

   For the purpose of: _____

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact info@chiroinjay.com

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7. A photocopy of this authorization shall be as valid as the original. The signature at the bottom of this page signifies that I either have received or waive my right to receive a signed copy of this authorization. By signing this authorization, I hereby acknowledge that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the subject individual's authorization or if conditioning is permitted by the privacy rule a statement about the consequences of refusing to sign the authorization.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

COMPLETE AND SUBMIT THIS FORM BY:
FAX TO: 518-730-0228
OR EMAIL TO: INFO@CHIROINJAY.COM