FLEXFIT CHIROPRACTIC

P: (541) 265-5550
F: (541) 265-7820
A: 1164 S.W. COAST HWY, SUITE G
NEWPORT, OR 97365

MEDICAL RECORDS
REQUEST AND RELEASE FORM

Patient's Name: _____ **DOB**: _____

Release From:_____	**Release To**:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
Fax:_____	Fax:_____

Type of General Medical Information to be Released:

☐ X-ray films *and* written reports - any spine imaging, and/or: _____
☐ MRI / CT written reports - any spine imaging, and/or: _____
☐ Medical records, including chart notes (regarding/date range): _____
☐ Other: _____

Expiration of Authorization of Release (Required):

This authorization is valid for 90 days from the date of the authorization or until (specify date) ___/___/_____, unless revoked by the patient orally or in writing at an earlier time. I understand I can revoke this authorization by contacting the HIPAA Privacy Officer at 1164 SW Coast Hwy, Ste G, Newport, Oregon; telephone 541-265-5550. The only exception is when FlexFit Chiropractic, LLC has already taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

Disclosure & Authorization Signature (Required):

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive health care services or reimbursement for services except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of FlexFit Chiropractic, LLC or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

THIS INFORMATION WILL BE USED ON MY BEHALF FOR THE PURPOSE OF REVIEW. By signing below, I authorize the specified medical records to be released as outlined above.

Signature:_____ _____ _____
Patient, Guardian, or Authorized Representative **Relationship to patient** **Date**