South Albany Chiropractic Clinic

2625 Queen Avenue Southeast
Albany, OR 97322
Phone: (541) 928-8266 | Fax: (541) 928-8915

Authorization to Release Medical Records and Medical Information

Please fill out this form carefully and completely. Much of the information is **REQUIRED** by Federal and State Law in order to comply with your release request.

Patient Name: _____

Other Names Used: _____

Date of Birth: _____ Social Security #_____

Current Address: _____

City: _____ Zip: _____

Daytime Phone: _____ Home Phone: _____

Purpose of Release Request:
____ Change of Doctor
____ Doctor Consultation
____ Moving/Relocating
____ Legal Reasons
____ Self Use (patient/representative will be charged a fee)

____ Other – Please Specify: _____

Type of Information to be Released/General Medical Information:
____ Physician Notes and Records (limited to two (2) years of information and excludes other protected records)
____ Lab Test Results. Please specify tests and their dates: _____

_____

____ Imaging Reports (X-Ray, MRI, etc.) Please specify tests and their dates: _____

_____
____ Electrocardiogram (ECG/EKG) Reports
____ Medication Record
____ Problem List
____ Operative Reports
____ Health Information Summary
____ Other Records or Test Results. Please specify information and dates: _____

_____

I authorize information to be released TO / FROM (circle one):

South Albany Chiropractic Clinic
2625 Queen Avenue Southeast
Albany, OR 97322

I authorize information to be released TO / FROM (circle one):

Please be complete and specific:

Name of Facility: _____

Street Address: _____

City, State, Zip Code: _____

Disclaimer Required:

Your general medical information may contain references to your mental state, drug and alcohol conditions, or HIV status or sexually transmitted diseases. Release of this information in your general medical record requires additional authorized signatures. We make every effort to prevent release of this information. However, we cannot guarantee that every reference to these conditions has been removed from your general medical records. We strongly suggest that your request indicate that the release of information should go to your personally for your inspection. You can then forward the information to whom you see fit.

Signature of Patient: (or legally responsible person – STATE RELATIONSHIP TO PATIENT)

_____Date: _____

Authorization to Fax Information:

I specifically give authorization to fax my medical information. I understand the risk involved in faxing records and that confidentiality at the receiving end cannot be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information.

Signature of Patient: (or legally responsible person – STATE RELATIONSHIP TO PATIENT)

_____Date: _____

This permission form is two pages and is from the office of Dr. Carl Hanson, D.C.