THE BACK ALLEY
CHIROPRACTIC & MASSAGE

Authorization to Use or Disclose Protected Health Information

You have a right to receive a completed copy of this form. Photocopy/fax copy may be used as original. ***Note to patient:*** A FEE may apply to this request for records. Arizona law states we must process requests for records within 30 days of the request.

PATIENT INFORMATION:

Name _____

Address _____

Date of Birth _____ Phone # _____

FACILITY RELEASING INFORMATION:

Name: The Back Alley Chiropractic & Massage

Address: 2060 E Tangerine Rd Ste 182

Oro Valley, AZ 85755-6251

Fax: 520-877-9183 Phone: 520-877-2666

TO WHOM INFORMATION IS BEING DISCLOSED:

Name: _____

Address: _____

_____

Fax: _____ Phone: _____

RECORDS BEING REQUESTED:

☐ Medical Records Dates From/To: _____ ☐ Radiology Reports ☐ Billing Records

☐ LMT Records & Billing ☐ Other _____

PURPOSE OF THE DISCLOSURE OF INFORMATION:

☐ Self ☐ Continuing care ☐ Insurance claim ☐ Other _____

An authorization to disclose PHI (Protected Health Information) is voluntary. Treatment, payment or eligibility for benefits will not be affected if you do not sign this authorization. Re-disclosure of a patient's PHI is prohibited without the specific written authorization of that person or as otherwise permitted by state or federal law. Information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law. This authorization pertains to the dates specified on this authorization. Unless you revoke this authorization earlier, it will expire 12 months from the date signed. You may revoke this authorization at any time by sending a written notice to the custodian of records.

Signature _____ Date: _____

Relationship to patient: _____

FOR OFFICE USE ONLY

Employee who reviewed/completed form with patient: _____

Date received: _____ Date completed: _____ Emp initials: _____

Comments: _____

Records picked up by: _____ Date: _____