



Authorization to Release Medical Information/Records

This Authorization is HIPPA compliant for use or disclosure of Protected Health Information.

By signing below, I, _____, authorize to use and disclose the protected health information identified below concerning:

Patient Name: _____

D.O.B.: _____

Social Security No: _____

This authorization includes the release of the following information:

To:

Harmonious Living Chiropractic: Fitness & Wellness Center, LLC
10 South Street, Suite 403, Baltimore, Maryland 21202

I understand that I have rights to inspect and receive a copy of the information to be disclosed. I understand that may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent to 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 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized 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 the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Printed Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date

Harmonious Living Chiropractic: Fitness & Wellness Center, LLC
10 South Street, Suite 403, Baltimore, Maryland 21202
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www.driffanybutler.com

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