Authorization

RELEASE OF MEDICAL INFORMATION

Patient name: ______________________________ Date of birth: ______________________________
Maiden name: ______________________________ Email: ______________________________
Phone: ______________________ Last 4 digits of Social Security number: ________ (optional)
Address: ____
City ______________________ State: __________ Zip: ____________

RECORD RELEASE

I authorize my records to be sent FROM:

Name/Organization: *Burkhart Chiropractic, PLC*
Phone: 616-698-0046
Address: *7101 Broadmoor Ave SE*
City: *Caledonia* State: *MI* Zip: *49316*

I authorize my records to be released TO:

Name/Organization: *Chapp Chiropractic, PLLC*
Phone: 616-698-6981
Address: *9090 South Rodgers Court SE, Suite B.*
City: *Caledonia* State: *MI* Zip: *49316*

INFORMATION REQUESTED

☒ Date of service(s): *Initial history and exam if performed from 11/2008 forward. Initial treatment if performed from 11/2008 forward. The last patient visit with Dr. Jim Chapp and all patient visits from 01/01/2019 to the present date of receiving this record release form.*

☒ Radiology reports *(any)*.

☒ History and Exam *(see* Date of service(s) *comments above)*

☒ Office visits *(see* Date of service(s) *comments above)*

▢ Other

RADIOLOGY IMAGES ONLY

Films to be released/From specific dates:

X-ray	CT Scan	MRI	Nuclear
▢ Images	▢ Images	▢ Images	▢ Images
▢ Reports	▢ Reports	▢ Reports	▢ Reports
☒ Both	☒ Both	☒ Both	☒ Both

Dates: *Most recent if any of the above images have been performed in digital format*

PURPOSE OF DISCLOSURE

NOTE: Patient is not required to complete this Purpose Of Disclosure section.

▢ Patient request ▢ Attorney/Legal Insurance ▢ Continued Patient Care

▢ Other (specify)

I understand that patient records from other health care providers may be released with this routine request. I also acknowledge that Chapp Chiropractic, PLLC assumes no responsibility or liability for the accuracy or legitimacy of any records originating with another provider.

There is potential that information disclosed under the authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA). However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form.

This authorization may be revoked in writing. Chapp Chiropractic, PLLC does not require this authorization as a condition for giving treatment, payment enrollment or eligibility for benefits.

This authorization will expire sixty (60) days from the date of my signature, unless I specify otherwise

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TIME __________ **DATE** __________ Patient or Legal Representative signature ______________________

Basis of legal authority to act for patient

Chapp Chiropractic, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

9090 S Rodgers CT SE, Suite B., Caledonia, MI 49316

616-698-6981 contact@chappchiropractic.com