Brewer Chiropractic Clinic
702 IH 20, Suite 100
Arlington, TX 76017
Phone (817) 467-2010 Fax (817) 465-0476

Authorization for Release of Protected Health Information

I hereby authorize _____ to release/disclose any medical record information and or protected health information to Brewer Chiropractic Clinic.

Patient Information

_____ _____ _____
Patient Name (Please Print) Date of Birth Social Security #

_____ _____
Telephone # Date of Treatment

Records Needed

Dates of medical records/protected health information requested: _____

For the purpose of: _____

Information to be released:

Face Sheet	Pathology Report	Cardiac Studies
Emergency Room Records	Laboratory Reports	Medication Record
History & Physical	Physician's Progress Notes	Consultations
EKG and EEG	Imaging/Radiology Reports	Operative Reports
Discharge Summary	Physician Orders	

Other (Specify): _____

Signatures

I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance on it. This authorization will expire in two (2) years from the date of my signature.

If you are claiming to be the patient's legal representative, you must indicate that authority and provide supporting documentation.

I understand that the information to be released may include information relating to sexually transmitted diseases, acquired immunodeficiency (AIDS or HIV), psychological or psychiatric treatment, behavioral or mental health services an alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I have read the above and authorize the release of the protected health information as stated above.

_____ _____ _____
Signature of Patient of Legal Representative Relationship to Patient Date