FIVE POINTS CHIROPRACTIC WELLNESS CENTER
1 N. Five Points Rd
West Chester, PA 19380
Phone #: 610-696-4363 Fax #: 610-696-4369

Authorization for Disclosure of Health Information

I hereby authorize Five Points Chiropractic Wellness Center to release medical information from the records of:

Patient Information:

Patient Name: _____ D.O.B _____ SS#: _____

Covering the period(s) of care (list applicable dates of treatment): _____

_____

Information to be disclosed: Check all applicable items to be release

____History & Intake form ____ Consultations ____SOAP Notes ____ Billing Information

____Other (please specify)_____

Purpose of the Disclosure: Please check one:

____ Further Medical Care ____Personal Use ____Insurance ____Legal

____ Other (please specify)_____

This information will be disclosed to:

Name of Person/ Institution: _____

Address: _____

City/ State/ Zip Code: _____ Phone #: _____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply this request. This authorization will automatically expire in 6 months unless otherwise revoked or indicate to expire on _____ (not to exceed the six months). In accordance with PA State law, I understand that there is a fee for obtaining copies of records, except for copies mailed directly to healthcare facility or physician, and I agree to pay such charges.

Five Points Chiropractic Wellness Center will not condition treatment, payment, enrollment or the eligibility for benefits on the completion of this authorization.

Information once released, may no longer be protected by Federal Privacy Rules and may be subject to re-disclosure by the recipient. However, information covered under Federal 42 CFR Part 2 may not be re-disclosed unless expressly permitted by the authorization or the regulations.

_____ _____ _____

Signature of Patient or Personal Representative **Relationship to Patient** **Date**