MYERS CHIROPRACTIC CLINIC
3 HAMPTON ROAD
EXETER, NH 03833
(603) 772-3981 (603) 772-7545 - Fax
WWW.MYERSCHIROPRACTICCLINIC.COM

Authorization to Release and Disclose Medical Information

PATIENT INFORMATION	NAME _____ DOB _____ ADDRESS_____ CITY _____ STATE _____ ZIP _____PHONE _____
RELEASE MEDICAL RECORDS FROM	☐ MYERS CHIROPRACTIC CLINIC ☐ NAME OF COMPANY _____ ADDRESS _____CITY _____ STATE _____ ZIP _____PHONE _____ FAX _____
RELEASE MEDICAL RECORDS TO	☐ MYERS CHIROPRACTIC CLINIC ☐ PATIENT/ PARENT/GUARDIAN : ☐ PICK UP ☐ MAIL/ FAX ☐ PORTAL ☐ NAME OF COMPANY _____ ADDRESS _____CITY _____ STATE _____ ZIP _____PHONE _____ FAX _____
MEDICAL RECORDS TO RELEASE	☐ OFFICE NOTES FROM:_____ TO:_____ ☐ BILLING RECORDS ☐ ENTIRE MEDICAL CHART ☐ XRAYS ☐ OTHER (specify record types) : _____
PURPOSE OF DISCLOSURE	☐ TRANSFERING CARE ☐ SHARING CARE ☐ PERSONAL COPY ☐ INSURANCE/ DISABILITY ☐ LEGAL PURPOSES ☐ FOR SCHOOL ☐ OTHER : _____

I understand that the information I have agreed to release may include but is not limited to sensitive information such as: sexually transmitted disease, AIDS, HIV, behavioral or mental health services, alcohol drug abuse treatment, sexual preference, counseling/family problems. I agree to its release. If you DO NOT WANT this information released please specify what information should NOT be released: _____

I understand that:

~I can see and copy the health information described above.

~I can refuse to sign this authorization and that my refusal will not affect payment, eligibility for benefits or my ability to obtain treatment.

~Under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

~I can revoke this authorization in writing to the address above at any time, but my revocation will not apply to information that has already been disclosed or used in response to this authorization.

~ Consent expires one year from date signed

Patient / Legal Guardian Signature_____Date_____

For Internal Use Only:

Records faxed to:_____on_____. Records mailed on:_____. Records sent to Portal on:_____

Completed by: _____

RECORDS PICKED UP BY PATIENT/ LEGAL GUARDIAN:

Signature: _____ Date _____