STARKWOOD CHIROPRACTIC

HIPAA FORMS

RELEASE OF INFORMATION AUTHORIZATION FORM

I, _____hereby authorize **Starkwood Chiropractic** and its affiliates, its employees and agents (collectively **Starkwood Chiropractic**), to release to _____ [Insert full name of person/organization] my personal health information maintained by **Starkwood Chiropractic** (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me:_____ [DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of **90 Days** or the date my coverage ends with _____ [INSERT INSURANCE COMPANY NAME]. I understand that I have a right to revoke this authorization by providing written notice to **Starkwood Chiropractic**. However, this authorization may not be revoked if **Starkwood Chiropractic**, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____
Signature of Member: _____
Date:_____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____
Signature of Legal Representative: _____
Date: _____
Name of Witness: _____
Signature of Witness: _____

OUR PATIENT PRIVACY NOTICE

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you and, the related administrative activities supporting your treatment. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization. As our patient, you have important rights relating to inspecting and copying your medical information that we maintain; amending or correcting that information.

We have available a detailed Notice of Privacy Practices poster on our wall in the reception area for your perusal.

PATIENT NAME:_____ **DATE**:_____

SIGNATURE OF PATIENT OR GUARDIAN:_____

STARKWOOD CHIROPRACTIC

Authorization for Release of Information

Patient Information:

Name:_____ DOB:_____ SS#:_____

Information to be released from:_____
Name of designated facility or provider

_____
Address

Information to be sent to:
Starkwood Chiropractic
11115 SE Stark St
Portland, OR 97216
Phone: 503-256-4830
Fax: 503-255-0758

Information to be released:

- ☐ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
- ☐ All medical records
- ☐ Specific information (Please specify):

_____

_____

Purpose for which disclosure is being made: (Please check one of the following)

- ☐ Attorney
- ☐ Insurance
- ☐ Doctor
- ☐ Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

**EXCLUDE the following information from the records released (Please initial):

_____Drug/Alcohol abuse/treatment & diagnosis _____Sexually Transmitted Disease
_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or Psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE:_____ **DATE:** _____
(Patient, Guardian* or Authorized Representative*)
(*Please provide documents to prove authority to sign on behalf of the patient.)