BAUMAN CHIROPRACTIC CLINIC OF NW FL.

3613 N. Hwy 231, Panama City Fl. 32404
Ph: 850-785-8311 Fax: 850-872-9892

MEDICAL RECORDS RELEASE

RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION

I HEREBY AUTHORIZE BAUMAN CHIROPRACTIC CLINIC OF NORTHWEST FLORIDA P.A. TO RELEASE A COPY OF MY PATIENT RECORDS, X-RAYS AND ACCOUNT RECORDS CONTAINING PROTECTED HEALTH INFORMATION TO: ____

THIS AUTHORIZATION IS GIVEN PURSUANT TO FLORIDA STATUTE 456.057 AND HIPAA REGULATIONS. I UNDERSTAND THAT FLORIDA STATUTE 456.057(10) MAKES CLEAR THAT ANY THIRD PARTY TO WHOM RECORDS ARE DISCLOSED IS PROHIBITED FROM FURTHER DISCLOSING ANY INFORMATION IN THE MEDICAL RECORD WITHOUT THE EXPRESSED WRITTEN CONSENT OF THE PATIENT OR THE IR LEGAL REPRESENTATIVES.

I UNDERSTAND THAT THIS INFORMATION MAY INCLUDE INFORMATION RELATING TO: ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION; TREATMENT FOR DRUG OR ALCOHOL ABUSE, MENTAL OR BEHAVIORAL HEALTH OR PSYCHIATRIC CARE, EXCLUDING PSYCHOTHERAPY NOTES. ANY RELEASE OF SUBSTANCE INFORMATION MUST BE PURSUANT TO 42 CFR. THERE ARE OTHER SPECIAL RESTRICTIONS WHICH APPLY TO THE RELEASE OF INFORMATION REGARDING HIV, ABUSE REPORTS, ETC…

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PATIENT OR GUARDIAN SIGNATURE **DATE SIGNED** **WITNESSED BY**

UNLESS OTHERWISE REVOKED, THE AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: ______________________________

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SPECIFIC DESCRIPTION OF INFORMATION REQUESTED AND DISCLOSED

I HEREBY ACKNOWLEDGE RECEIPT OF THESE RECORDS AND/OR X-RAYS. IN CONSIDERATION OF THE FOREGOING, I HEREBY RELEASE ANK FOREVER DISCHARGE THE AFORESAID DOCTOR OF CHIROPRACTIC FROM ANY AND ALL RESPONSIBILITY OR LIABLITY OF ANY KIND, NATURE OR CHARACTER WHATSOEVER ARISING FROM SAID TREATMENT. **TAX ID 80-000-9303**

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SIGNATURE / RECEIPT OF RECORDS **DATE**