Healthy Back Chiropractic
1707 Lansing Ave. NE Salem, OR 97301
phone: (503) 589-0700 fax: (503) 586-0255
HealthyBackChiropractic.com

RELEASE OF HEALTHCARE INFORMATION AUTHORIZATION FORM

Patient's Full Name _____ Date of Birth _____

Previous Name(s) _____ Social Security Number _____

I request and authorize (facility/doctor) _____

to release healthcare information of the patient above to:

Name _____

Address _____

Phone _____ Fax _____

This request and authorization applies to (please circle all that apply):

Inpatient Outpatient Emergency

All Date(s) of service Specific Date of Service _____

Treatment Notes	Discharge Summary
Laboratory/Pathology Reports	All records not requiring "Special Release"*
Surgical Reports	All records for this patient
Radiology/MRI Reports	Other (please specify)
Intake Documentation	_____

*Psychotherapy notes and STD testing and/or results or test require a special release. Should you wish to authorize release of this information, please request a "Special Release Authorization Form".

- I understand this consent is voluntary. If I refuse, the identified records will not be disclosed. Whether I sign or refuse, my treatment will not be affected.
- I understand I have a right to receive a copy of this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Patient's Signature _____ Date _____

THIS AUTHORIZATION WILL EXPIRE 3 MONTHS FROM THE DATE SIGNED. AUTHORIZATION MAY BE WITHDRAWN IN WRITING BY THE PATIENT (EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN BASED ON THIS CONSENT).