1187 Old Hickory Blvd.
Brentwood, TN 37027
615.377.7770   615.377.0448

AUTHORIZATION FOR RELEASE OF INFORMATION

I, __________________________________, authorize Skye Chiropractic to disclose health information regarding the below referenced patient. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: ______________________________ DOB:____/____/______ SSN: _________________________

Address: ______________________________________City:_____________________ St: ______ Zip: _________

Specific description of information to be disclosed to the following persons/organization (including dates):

____

____

____

Purpose of the use or disclosure: ____At the request of the individual ____Changing Doctor ____Moving

____Physician/Staff Request _____Personal Injury ____Other: ______________________________________

I understand that I may revoke this authorization at any time by sending a written request to the Practice. However, the revocation will not have any effect on any uses or disclosures the Practice may have made before the revocation was received.

I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) months after the date this authorization is signed. I understand that I may refuse to sign this authorization and that the Practice will not condition treatment on whether or not I sign this authorization.

I certify that I am:

____the patient.

____the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship is that of _______________________________.

Signature: __________________________________ Date: _______________

If signature is not that of patient: Print Name: __________________________________

Address: _____________________________________

____

Phone #: _____________________________________

Office Representative: ___________________________ Date: _________________

*A copy of this authorization is available and may be retained by patient.