Van Dam Chiropractic, P.C.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________________ Chart#: ______________________________

Maiden/Other: ______________________________ Birth date: ___________________________

I hereby authorize:____

to release my records to: **Dr. Scott Van Dam**
Van Dam Chiropractic, P.C.
1203 28TH ST S Suite B
Fargo ND 58103
P: 701*532*5320 F: 701*280*2915

The disclosure is being made for the following purpose(s):

___ Diagnosis and Treatment

___ Insurance/Billing

___ Personal

____ Legal

____ Other: _______________________

I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulation, the information described above may be redisclosed and no longer protected by these regulations.

INFORMATION TO BE RELEASED AND DATE OF SERVICE:

___ Pertinent Records for Continuing Care ( )
___ Discharge Summaries ( )
___ History & Physical ( )
___ Report of Operations ( )
___ Consultations ( )
___ Pathology Reports ( )
___ Radiology films ( )
___ Radiology reports ( )
___ MRI and/or CT reports ( )

___ Chiropractic records ( )
___ OB/GYN ( )
___ Pediatric ( )
___ Immunizations ( )
___ Oncology ( )
___ Physical Medicine ( )
___ Pathology Reports ( )
___ Laboratory Reports ( )
___ Neurology Records ( )

___ Other: ____

AUTHORIZATION OF RELEASE OF THE INDICATED SENSITIVE RECORDS (requires patient's initials):

	Initials		Initials
___ HIV or AIDS	______________	___ Mental Health	____________
___ Chemical Dependency	______________	___ Other: ________________	____________

I release the above-named healthcare provider form all legal responsibility and/or liability that may arise from the release of the records I have specified.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except as permitted by law.

I understand I may revoke this authorization in writing to the clinic at any time except to the extent that action has been taken in reliance on this authorization or if the authorization was obtained as a condition of obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy or the policy itself. This authorization will remain in effect indefinitely unless I inform the clinic in writing of my intent to revoke the authorization.

_____________________________________ _____________________________________
Signature of Patient or Representative Date

_____________________________________ _____________________________________
Name of Personal Representative (if applicable) Relationship to the patient as a legal representative

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Van Dam Chiropractic, P.C.