BACK TO WELLNESS CLINIC OF RUTLEDGE

113 Fairplay Street
Rutledge, GA 30663

(706) 557-0211
fax (706) 557-0213

Authorization to **RELEASE** protected health information

_____ PRINT PATIENT'S Full Name

_____ PATIENT'S Date of Birth

_____ PRINT Name of Parent/Legal Guardian

_____ DAY area code & phone number

Please check one: I am the: ☐ Patient (must be 18 years of age or older) ☐ Parent ☐ Legal guardian

☐ Call to pick up records when ready: OR ☐ Mail records to: _____

_____ Day area code & phone number

_____

_____

*I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
*I authorize the inspection of the above information by the above named agency/person and/or to the furnishing of a Photostat or other copies.
*I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to Back to Wellness Chiropractic Clinic receiving a written notice of withdrawal
*I hereby release Back to Wellness Chiropractic Clinic and its employees from any and all liabilities, responsibilities, damages, losses and claims, which might arise from the release of the information authorized above.
*In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
*I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the individual or agency named above.

Treatment location(s) from which you would like records released: _____

The following information is to be released: Check correct documents.

☐ Autopsy Report	☐ Face Sheet	☐ Nurse Notes	☐ Radiology Reports
☐ Clinic Notes	☐ History & Physical Exam Report	☐ Operative Reports	☐ Rehabilitation Records
☐ Consultations	☐ Immunization Records	☐ Pathology Reports	☐ Therapy Notes
☐ Discharge Summary	☐ Laboratory Reports	☐ Photographs	☐ ALL OF THE ABOVE
☐ Doctors Orders	☐ Medication Records	☐ Progress Notes	☐ Other (specify) _____
☐ Emergency Room Record	☐ Neuropsychological Reports	☐ Psychosocial Notes	_____

Applicable Dates/Encounters: _____

The purpose for which this release is being requested is: ☐ continuing medical care ☐ legal action ☐ insurance reimbursement

☐ other _____ ☐ Undeclared (at the request of the below signed)

Any disclosure of medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization.

This authorization expires _____ (insert applicable date or insert "no expiration designated") or in 6 months (12 months for school requests). Whichever is shorter, and no further use/disclosures as described above may be made after the expiration. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature unless otherwise specified. Specific exceptions for future-dated releases are: School Other _____

Signature: _____ Date: _____