1660 S. Horner Blvd.
Sanford, NC 27330

Phone: 919-777-9999
Fax: 919-777-9998

## HIPAA AUTHORIZATION FORM
## RELEASE FOR MEDICAL OR HOSPITAL INFORMATION

I, _______________________________________________ Authorize _____________________________________
PRINT NAME

to release or disclose my protected health information, to include, full and complete medical records, patient histories,

discharge summaries, operative notes, office notes, examination and test results, and films that may be in your possession

regarding treatment ________________________________________________________________________.

**PLEASE FAX A.S.A.P. – Patient in office – THANK YOU!** ☺

The following office or class of persons may receive disclosure of protected health information about me:

**Nelson & Nelson Chiropractic**
**1660 Horner Boulevard**
**Sanford, NC 27330**

I understand that the information used or disclosure may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

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. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the Privacy Officer. I further understand that I may revoke this authorization to the extent that action has been taken in reliance on this authorization. This authorization expires ___________________________. (No longer than one year from dated signed).

Date: ________________________________________

Signature of Individual: ______________________________ Print Name: ________________________________________

Patient's Date of Birth: _____ / _____ / _____

Witness: ________________________________________________________ Date: _____ / _____ / _____

**NOTE:** All medical information is confidential. According to Federal and State Regulations, the above requested information will be released only to the requesting doctor, facility, or agency for the purpose stated.