Chiropractic Kids Clinic
helping kids ages 0 to 99 plus

Vanessa K. King, DC, MSN, MTAA
Chiropratic Physician

1.844.5HIKIDS (544-5437) | 1.888.977.3045 fax | 2705 St. Peters Howell Rd, Suite H St. Peters, MO 63376 | ChiropracticKidsClinic.com | DrKing@ChiropraticKidsClinic.com

Authorization to Release Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This form implements the requirements for client authorization to use and disclose health information protected by federal healthy privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), federal law pertaining to Early Childhood Intervention (34 C.F.R. part 300), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services.

Patient Name

Date of Birth or Age

Chiropractic Kids Clinic

Persons/organizations authorized to provide the Information

Persons/organizations receiving the information

Date of Request

Persons/organizations receiving the information
Street Address

Persons/organizations receiving the information
City, State, and zip code

Specify description of information (including dates):

(Circle) <u>All</u> records of or other information regarding my treatment for all dates OR **<u>Other</u>** (please specify below):

Purpose of the disclosure:

I understand that this authorization will expire on _____ (provide date) or one year from the date it is signed, whichever is earlier. Initials:_____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received. Initials:_____

I understand that I am authorizing the release of substance abuse, AIDS, HIV, or other communicable diseases, if such information is present in my record. Initials_____

Signature of Patient or Patient's Representative
(Form MUST be completed before signing).

Date

Printed Name of Patient or Representative

Relationship to Patient

Patient or Patient's Representative
Street Address

Patient or Patient's Representative
City, State, and Zip Code

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION