Belmont Chiropractic Center
Phone: 704-825-9799

5803 Wilkinson Blvd. Belmont NC 28012
Fax: 704-825-9977

Patient Name: _____ DOB: _____

I hereby authorize Belmont Chiropractic Center to:
_____ release medical records (protected health information) to (specify person/organization *and address below); or,*
_____ obtain medical records (protected health information) from (specify person/organization and address below).

Name: _____

Address: _____

I understand that the medical records, which I have requested to be released, may contain information regarding mental illness, HIV/AIDS and/or substance abuse (drugs and/or alcohol). I further understand my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse, 42 CFR Part 2, and cannot be disclosed without my written consent as stated below unless otherwise provided for in the regulations:

- I ___ do ___ do not authorize release of information related to AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infections.
- *I ___ do ___ do not authorize release of information related to psychiatric* care and/or psychological assessment.
- I ___ do ___ do not authorize release of information related to treatment for alcohol and/or drug abuse.

Information to be disclosed: (please check the appropriate box or boxes below)
Date(s) of service: _____

__Entire Record	__Discharge Summary	__ History & Physical	__Consultation Reports
__Autopsy Reports	__Physician Orders	__Physician Progress Notes	__Pathology Report
__Nursing Data/Notes	__Radiology Reports	__Laboratory Results	__ER Record
__Operative Reports	__Other (please specify)_____		

Purpose of Disclosure: The above information is released for the following purpose (please check the appropriate box or boxes listed below) and that purpose only. Any other disclosure is prohibited without my specific written authorization.

__Transfer Medical Care to (Doctor's Name):_____		__Personal use/individual's request
__Physician Request	__Insurance Use	__Other (please specify):
__Legal/Attorney use	__Child/Adult Protective Services	_____

I hereby acknowledge this authorization is voluntary and is valid until such request is fulfilled but not to exceed 1 year from the date signed. I release, discharge and agree to hold harmless all parties to whom this authorization is given from any liability that may arise from the release of information authorized above. I may revoke this request, in writing, at any time except to the extent that action based on this authorization has taken place. I understand that a photocopy or facsimile transmission of this authorization is considered acceptable in lieu of the original. I understand I don not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be disclosed by the recipient and may be disclosed by the recipient and may no longer be protected by federal privacy regulations.

_____ _____
Signature of patient or authorized legal representative Relationship of authorized representative to patient
Date _____