Core Chiropractic & Wellness
2611 NE 125th St., Suite 240, Seattle WA 98125
Phone: (206) 708-7172 Fax: (206) 913-2568

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I hereby authorize:

Core Chiropractic & Wellness, Dr._____
Facility/Providers Name: _____
Address: _____
City: _____State: _____ Zip: _____
Phone #:_____ Fax #: _____

To release:
Complete Chart (includes all chart notes, labs and reports but will NOT include billing or insurance documents unless specifically requested below)

Chart Notes All Specify_____
Labs and Reports All Specify_____
Billing Records All Specify_____
Imaging Reports All Specify_____
Other: _____

From the health records of:
Name: _____ Date of Birth: _____
Social Security number: _____ Phone # : _____

Are you authorizing release of your own records? YES NO
If not, what is your relationship to the patient? _____(Release of certain medical information requires a minor's consent. This applies to information pertaining to substance abuse, mental health information, sexually transmitted diseases, HIV and AIDS. Others may apply.)

To be released to:

Facility/Provider Name: _____
Address: _____
City: _____ State _____ Zip _____
Phone: ( ) _____ Fax # ( ) _____

Myself (Provide current address below) – fee may apply☐
Address: _____
City: _____ State: _____ Zip: _____

Core Chiropractic & Wellness Dr._____
Lake City Professional Center 2611 NE 125th St. Suite 240, Seattle, WA 98125

For the purpose of: Concurrent care Transfer of care Other (specify)_____

I understand that unless revoked this authorization is valid for 90 days form the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: check below to EXCLUDE information from authorization related to Substance abuse Mental Health conditions/psychotherapy Sexually transmitted diseases and HIV / AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would be no longer protected. I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call (206)708-7172 to inquire about revoking authorization. I understand that if I request records for personal use, to hand carry to another healthcare provider or for parties not involved in my health care, there may be a charge. Non-emergency release of records may take up to 15 working days. Emergency requests will be given priority. Emergency status applies only to release of records directly to another healthcare provider for urgent patient care.

Patient's signature: _____ Date: _____

Representative/guardian's signature: _____ Date: _____