STRATER FAMILY CHIROPRACTIC

Dr. Janaina Strater **Dr. Joseph Strater**

Authorization to Use and Disclose Health Information

(Request for copies of medical records)

1. I authorize the use or disclosure of the below named individual's health information as described below.
2. The type of information to be used or disclosed (check the appropriate items and include other information as needed) is:
   - ☐ Entire medical record ☐ History and physical ☐ Radiology reports ☐ ER record
   - ☐ Cardiology reports ☐ Physician orders ☐ Progress notes ☐ Discharge summary
   - ☐ Lab results (specify dates) _____
   - ☐ Consultation report(s) by _____
   - ☐ Other (please specify, i.e., vascular lab, pulmonary or other ancillary visits)_____
3. Date(s) of Service Requesting: _____
4. I understand the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. I authorize _____ to make the disclosure to the individual or organization identified below.
6. The items indicated above may be used by or disclosed to the following individual or organization:
   Name: **Strater Family Chiropractic** Phone: **(321) 866-0200** Fax**: (321) 866-0201**
   Address: **309 N. Orlando Ave, Cocoa Beach, FL 32931**
7. This information for which I am authorizing disclosure will be used for the following purpose:
   - ☐ Continued care / Dr. Strater ☐ My personal records ☐ Legal purpose
   - ☐ Other, please describe _____
8. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department where my information is maintained.
   I understand that the revocation will not apply to information that has already been released in response to this authorization.
   I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
9. This authorization will expire six months from the date signed, which will be (date) _____(If the expiration date of this authorization is not completed, this authorization will expire six months from the date of which it was signed.)
10. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
11. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
12. If I have questions about disclosure of my health information, I can contact the Medical Records Department where I received treatment.

_____ _____
Signature Date

_____ ____/____/_____ _____-_____-_____
Print Name Date of Birth Social Security Number

_____
Name of Personal Representative

_____
Description of Personal Representative's Authority