Release of Information Authorization Form

Date of Birth: ___/___/___

I hereby authorize Impact Family Chiropractic and Dr. Vann, employees and agents collectively to release information.

Information to Be Used or Disclosed ○The Information covered by this authorization includes:
□ **Healthcare and Financial Records** (Healthcare records include examination findings, treatments, lab/imaging results, health information gathered on your behalf. Financial Records include co-payments, or deductibles you have paid for care, or balances owed.)
□ Healthcare Records
□ Financial Records

Purposes of Disclosure ○Information listed above will be disclosed for the following purposes:
□ **All of the Following**

□Primary Insurance Carrier	□ Personal Attorney	□ Other: _____
□Secondary Insurance Carrier	□ Guardian/Parent	_____
□Other Healthcare Providers as described Above	□ Spouse	_____

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated in writing earlier by the patient or the patients personal representative.

Right to Terminate or Revoke Authorization
I understand that I have the right to revoke this authorization by providing written notice to Dr. Vann and Impact Family Chiropractic. However, this authorization may not be revoked if Impact Family Chiropractic, its employees or agents have taken action on this authorization prior to receiving written notice. I also understand that I have a right to have a copy of this authorization.

Potential for Redisclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your rights to the protection of the privacy of this information once Impact Family Chiropractic discloses it to another party.

Rights of the Individual
You may inspect or copy information used or disclosed , under this authorization. You may refuse to sign this authorization. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditional on whether I sign the authorization.

I prefer these records be released:
□ Any of the following
□ Directly to me
□ Sent by Mail to Address on File, or provide New Address _____
□ Sent by Fax Fax #: _____
□ Sent by Email to Email on File, or provide New Email _____

_____	_____	_____/_____/_____
Name of the Patient	Signature of the Patient	Date
_____	_____	_____/_____/_____
Name of Witness	Signature of the Witness	Date

If applicable, Legal Representative Sign below ○ By Signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (*e.g. Power of Attorney, living will, guardianship papers ect.*) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____	_____	_____/_____/_____
Name of Legal Representative	Signature of Legal Representative	Date
_____	_____	_____/_____/_____
Name of Witness	Signature of the Witness	Date

IMPACT Family Chiropractic