VIC Authorization for Disclosure of Information for Minors

Authorization for Disclosure of Information

This form authorizes the use, disclosure, and exchange of your personal health information as required for treatment and other healthcare operations.

**CLIENT INFORMATION

Name:

Date of Birth:

Authorization Details

I hereby authorize and direct **Valley Integrative Chiropractic LLC:**

To disclose and/or exchange the following information (check all that apply):

- ☐ Entire Medical Record
- ☐ Specific Records Only (please list below)

If you selected "Specific Records", please list below:
Ex: start and end date range, type of records

To: Name of Recipient/Organization:
Who the records will go TO (Provide organization name here)

Recipient Name and Address to send Records TO

If an organization, leave the name fields blank and put organization name above

Legal first name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Purpose of Disclosure

The purpose of this disclosure is for (check all that apply):

- ☐ Continuity of Care
- ☐ Coordination of Services
- ☐ Billing and Payment
- ☐ Insurance Claims
- ☐ Legal Reasons
- ☐ Personal Use
- ☐ Other

If you selected "Other", please list below:

Expiration of Authorization

This authorization will expire on:

- ☐ A Specific Date (list below)
- ☐ 90 days from the date signed

If you chose "A Specific Date", please add the date below:

Acknowledgment and Consent

By signing below, I acknowledge that:

-I understand that my records may contain sensitive health information.

-I consent to the release of this information as indicated above.

-I am aware that my records are protected by state and federal laws and cannot be disclosed without my written consent unless otherwise required by law.

-I may revoke this authorization at any time *in writing*, except to the extent that action has already been taken based on this authorization.

-I am that I am the parent or legal guardian of the above named patient, and in signing this document, I affirm that I have the legal right to make these decisions.

Client

X _____

Print name: **Date:**