MALKMUS

Chiropractic Acupuncture

Authorization For Release Of Medical/Health Information

I, _____ do hereby authorize and request that **Malkmus Chiropractic and Acupuncture LLC**, release or disclose to _____ the health information specified below that relates to the following individual:

(Name of Individual, Guardian, Legal or Personal Representative)

(Name of Entity, Agency, Individual, or Class Intended To Receive Information)

Name:	Date Of Birth:	Social Security Number:
Address, City, State		Other ID:

Specific Information To Be Disclosed (Check All That Apply)

☐ Entire Record	☐ Progress Notes (*)	☐ Medical History, Examination, Diagnosis
☐ Treatment or Tests	☐ Physical Exam Forms	☐ X-Ray Reports
☐ Laboratory Reports	☐ Daily Chart Notes (*)	☐ X-Ray Films

☐ Other (Specify):

_____

_____

_____

* **Note that: Progress notes, and daily chart notes are in SOAP note format, which includes a subjective, objective, assessment, and plan portion to each note. These note sections will thus, by nature, include physical examination results, diagnosis, prognosis, patient progress, treatment procedures, and treatment plans.**

Phone: (417) • 614 • 5222 | Email: info@malkmuschiropractic.com | Fax: (417) • 614 • 2288

2053 S. Waverly Ave, STE B, Springfield, Missouri, 65804

Include Information Within The Following Date(s):			
Party To Which Information Is To Be Disclosed			
Name:	Phone:		Fax:
Address:	City:	State:	Zip:

Purpose of Request for Disclosure

☐ At the request of the individual or individual's legal representative
☐ Other (Specify): _____

Your Rights With Respect To This Authorization

This authorization is to be valid for 1 year after the date of signing. You cannot be required to sign this disclosure authorization form, nor may treatment or payment be refused if you do not sign. You have the right to inspect the information to be disclosed, and you may revoke this authorization. A revocation of this authorization will not reverse disclosures already made under this authorization and when a disclosure occurs, there is a possibility the information might be re-disclosed by the recipient.

Signature

I have had an opportunity to review and understand the content of this authorization form, and by signing this authorization, I confirm it accurately reflects my wishes. If a guardian, legal representative or a personal representative sign this document they must provide separate documentation of their status and authority.

Signed (Individual, Guardian, Legal or Personal Representative):	Date:

Phone: (417) • 614 • 5222 | Email: info@malkmuschiropractic.com | Fax: (417) • 614 • 2288
2053 S. Waverly Ave, STE B, Springfield, Missouri, 65804