CHIROPRACTIC HEALTH CENTER

Dr. Michael Urbanc, D.C.
9687 Brookpark Road, Parma, Ohio 44129
Phone: (216) 898-1445
Fax: (216) 898-1447

Date: _____ TO: _____

Fax #: _____ Address:_____

_____

D.O.B. _____ _____

SSN#: _____ Reason for disclosure:_____

_____

Patient Name:_____ DOI:_____

I do hereby authorize any physician, hospital, or other person to furnish to the Chiropractic Health Center, any and all records, information, and reports pertaining to treatment rendered from your facility. This authorization extends to all or any part of the records designated above, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis. A photocopy of this authorization is as valid as the original.

I understand that the Provider referenced will not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to our exempted from the Federal Privacy Requirements of the Health Insurance Portability and Accountability Act of 1996. (HIPPA) as they administer workers' compensation programs and injury claims. Information disclosed pursuant to this authorization may be re-disclosed by them and may no longer be protected by the Federal Privacy requirements.

DATE:_____ _____

Signature of patient

✔ Complete Chart including nurses notes

✔ Office Notes and/or physical therapy records

✔ Itemized patient bill for services rendered

✔ Other:_____