# HIPAA Medical Records Release Form

## Print or Type

Name:_____
Last First Middle

Social Security # _____-_____-_____ Date of Birth_____ Phone_____

**Please give name and address of medical facility you are authorizing your medical records be released from:**

Physician/Clinic:_____

Address:_____

Phone:_____Fax: _____

**I authorize my medical records be released to:**

Name:_____

Address:_____

Phone:_____ Fax:_____

**Check all records to be released**

☐ All Medical Records ☐ Billing Only

☐ Other (specify) _____

**Purpose of records being released:**

☐ Continuity of care ☐ Personal copy ☐ Insurance claim

☐ Legal claim ☐ Disability claim ☐ Other

This authorization is in effect from _____ to _____. Upon conclusion of this time, this authorization is automatically revoked.

I understand that:

- I may refuse to sign this authorization and that my refusal has no impact on receiving treatment
- I can inspect or copy any information disclosed under this agreement
- My signing the document is voluntary
- I can revoke authorization at any time, except to the extent that the practice has acted upon this authorization and revocation must be in writing
- I can receive a copy of this authorization
- Federal laws will not cover information once it is released

Patient/Legal Guardian Signature:_____ Date:

Witness: Date:_____

Identification of requestor of patient information is verified: Yes ☐ No ☐ Type _____

**Return Completed form along with a copy of your drivers license and a $5.00 money order to PO Box 183, Muncie, IN 47308 or email to recordsrequest@jeffersoncountychiropractic.net.**