GOFFSTOWN CHIROPRACTIC CARE, PLLC
17A Tatro Drive, Suite 101
Goffstown, NH 03045
Telephone: (603) 384-1680
Fax: (603) 384-1679
www.goffstownchirocare.com

AUTHORIZATION FOR REQUEST FOR INFORMATION

I hereby authorize Goffstown Chiropractic Care, PLLC and any of its appointed assistants to obtain the following information from the healthcare record of:

Patient Name _____ Date of Birth _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

This information is to be received from:

Agency/Business Name _____ Contact Name (if applicable) _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

For the purpose of (please check one):

- ❑ Changing provider
- ❑ Chiropractic treatment
- ❑ At the request of the individual
- ❑ Other (please describe) _____

Information to be disclosed: ***<u>PLEASE FAX ALL REPORTS TO (603) 384-1679</u>***

- ❑ Office notes for date(s) of service _____
- ❑ X-ray reports of _____for date(s) of service _____
- ❑ MRI reports of _____for date(s) of service _____
- ❑ CT scan reports of _____for date(s) of service _____
- ❑ Complete healthcare record
- ❑ CD(s) containing images of above marked studies – **<u>PLEASE MAIL TO ADDRESS LISTED ABOVE</u>**
- ❑ Other (please describe) _____

Special instructions: _____

I Understand that:

- Treatment will not be conditional on whether I sign this Authorization.
- This Authorization is voluntary and I have the right to refuse to sign it.
- This Authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date).
- If I sign this Authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice. Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the Authorization.
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
- Once signed, the Practice will provide me with a copy of this Authorization.

_____ _____

Signature of patient/guardian Date

_____

Printed name of patient/guardian

For office use only (initial and date)

- ❑ Report(s) received _____
- ❑ CD(s) received: _____
- ❑ Documents received: _____