JAYMAC CHIROPRACTIC
FAMILY HEALTH & WELLNESS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize JayMac Chiropractic and any of its appointed assistants to obtain or share the following information from my healthcare record.

Patient Name _____ Date of Birth _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

This information is to be shared with or obtained from:

JAYMAC CHIROPRACTIC
22711 S. ELLSWORTH RD, # G106, QUEEN CREEK, AZ 85142
OFFICE: (480) 264-6800 **FAX:** (480) 300-4688 info@JayMacChiropractic.com

I authorize the following entity to share or obtain all or portion of my healthcare record:

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

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

For the purpose of:

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

Information to be disclosed:

❑ 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
❑ Other (please describe) _____

I understand that treatment will not be conditional on whether I sign this Authorization and that this Authorization is voluntary and I have the right to refuse to sign it. I further understand that this Authorization will remain in effect for one year from the date of the signature below, unless I specify a different date here: _____. I understand that if I sign this Authorization, I may revoke it later by sending a written notice of revocation to the privacy officer at JayMac Chiropractic. Note: The only exception to my right to revoke is if JayMac Chiropractic 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, I understand that I will be provided with a copy of this Authorization.

_____ _____
Signature of patient/guardian Date

_____
Printed name of patient/guardian