St. Cloud Chiropractic Clinic & CLEAR Scoliosis Center

Authorization for the Use and Disclosure

Of Protected Health Information

To: _____

_____

_____

Attention: _____

This authorization is being requested for Clinical Care regarding the following patient:

Name: _____ Date: _____

Signature: _____

Birthdate: _____ Social Security # (optional) _____

The following information should be released to the St. Cloud Chiropractic Clinic, P.A.

( ) Office Notes, Reports, and Records

( ) MRI and / or X-Ray Reports

( ) X-Ray films

( ) Other: _____

Note: Once agreed to, the patient has the right to revoke this authorization as is deemed necessary. Your care in this clinic will not be deemed conditional on agreeing to this authorization. The information released under this authorization may be re-disclosed by the party receiving the information. We have no control over such re-disclosures. Unless otherwise indicated, this authorization shall expire upon the request of you (the patient) or your personal representative.