Manley Chiropractic

4602 Park Springs Blvd., Suite 150
Arlington, TX 76014
817-784-2330 817-784-2320 Fax

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____ , authorize: _____
(Name of Individual)

_____ _____
(Social Security Number)

_____ _____
(DOB)

to release my Protected Health Information, as described below, to:

RECIPIE.NT(S) INFORMATION:

Dr. Jeff Manley, D.C., D.A.B.C.O.
Name of Health Care Provider/Plan/Other Name of Health Care Provider/Plan/Other

4602 Park Springs Blvd., Suite150
Street Address Street Address

Arlington, TX 76017
City. State. Zip Code

I request that the information to be released consist of the following: (CHECK ALL THAT APPLY):

___Complete Medical Record ___Medical History, Evaluation Records ___Immunizations
___Treatment or Tests ___Hospital Records Including Reports ___X-ray Reports
___Allergy Records ___Laboratory Reports ___Prescription Data
___Consultation Documentation ___Surgical Reports
___Other (Specify): _____

I also specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY): ___HIV/AIDS, ___Substance Abuse (alcoholism or drug abuse), or ___Mental Health
be released to the above referenced recipients.

It is my understanding that the information to be released will be used for the following purposes (CHECK ALL THA T APPLY):

___At the request of the individual (no purpose need be specified) ___Additional Medical Care
___Insurance Eligibility/Benefits ___Change of Provider ___Legal Investigation or Action
___Other (Specify):

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy Standards and my health information may be redisclosed by the recipient without obtaining any further authorization.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:
I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke this Authorization by notifying the practice in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact: Jeff Manley at (817) 7842330. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until _____

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

INDIVIDUAL'S SIGNATURE: REPRESENTATIVE'S SIGNATURE (IF APPLICABLE):

_____ _____
DESCRIPTION OF REPRESENTATIVE'S RELATIONSHIP:

DATE: _____