



3017 E. Francis Ave. STE 101, Spokane, WA 99208

◆ P: (509) 467-7991 ◆ F: (509) 467-4834 ◆ EIN: 26-3480486

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

Patient Name: _____ *DOB:* _____

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| <input type="checkbox"/> SECTION A — Send Records TO Valente Chiropractic Use this section when another clinic, hospital, attorney, or provider is sending records to Valente. | |
| RELEASE RECORDS FROM _____ ADDRESS: _____ _____ PHONE: _____ FAX: _____ | SEND RECORDS TO Valente Chiropractic PLLC 3017 E. Francis Ave. STE 101, Spokane, WA 99208 Fax: (509) 467-4834 |

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|--|---|
| <input type="checkbox"/> SECTION B — Request Records FROM Valente Chiropractic Use this section when Valente is sending records to another clinic, hospital, attorney, or recipient. | |
| RELEASE RECORDS FROM Valente Chiropractic PLLC 3017 E. Francis Ave. STE 101, Spokane, WA 99208 Fax: (509) 467-4834 | SEND RECORDS TO _____ ADDRESS: _____ _____ PHONE: _____ FAX: _____ |

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| Information to release: <input type="checkbox"/> Medical records <input type="checkbox"/> X-ray images/films <input type="checkbox"/> X-ray reports <input type="checkbox"/> Billing records <input type="checkbox"/> Other: _____ |
| Dates of records: From ___ / ___ / _____ To ___ / ___ / _____ <input type="checkbox"/> Any and all dates |
| Purpose: <input type="checkbox"/> At my Request <input type="checkbox"/> Continuing Care <input type="checkbox"/> Legal/Attorney <input type="checkbox"/> Other: _____ |

Authorization and Patient Rights: By signing this form, I authorize the release of the health information selected above for the purpose of my request. This authorization expires one year from the signature date unless I revoke it sooner in writing. I may revoke this authorization in writing, but revocation will not affect action already taken in reliance on it. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA. I may request a copy of this signed authorization. Record-copy fees may apply where permitted by law.

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| PATIENT OR LEGAL REPRESENTATIVE SIGNATURE _____ PRINTED NAME _____ | DATE _____ RELATIONSHIP TO PATIENT _____ |
|---|---|

If signing for the patient, state your authority to act for the patient: _____