8333 Gunn Hwy. Tampa FL
813-926-9500P 813-433-5517F

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

Social Security: _____ Date of Service: _____

Provider Name: _____ Provider Phone: _____

Recipients Name: OptiLife Chiropractic –Dr. Danielle Hoeffner & Dr. Erica Berns

Address: 8333 Gunn Hwy. Tampa, FL 33626
Phone: 813-926-9500
Fax: 813-433-5517

This authorization will expire on the following date: _____(Day, Month, Year)

Purpose of disclosure: Review Medical Records

Is this request for psychotherapy notes? __ Yes, then this is the only item you may request on this form.
__ No, then you may check as many items below as you need.

Is this request of PHI for the purpose of marketing? __ Yes, then will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? __ Yes __ No

Please fax the checked items as soon as possible:

___Entire Medical Records ___Discharge Summary ___Pathology Report ___X-ray and/or MRI Reports

___X-ray/Scans ___Operative Report ___Other:_____

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIS information.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may request a copy of this form after I sign it.

I HAVE READ THE ABOVE & AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED.

Patient/Guardian Name: _____ Date: _____

Patient/Guardian Signature: _____