ExactaCare

Chiropractic & Injury Rehab

Medical Records Release Form:

By signing this form below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and if the person/organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I agree a copy of this form may be treated as a signed original.

Purpose of Release:

➢ Continued Medical Care

➢ Insurance

➢ Attorney

Information Being Released:

➢ All Records, medical and billing

➢ Specific Information by Request

I understand that the information released may contain records regarding mental health, developmental disability, alcohol or drug abuse and/or infectious disease (Including HIV, AIDS, or AIDS related conditions) unless specifically requested not to include these records.

I understand that I may revoke this authorization at any time within sixty (60) days by notifying Exacta Care. This revocation will not affect any actions already completed.

Patient Name: _____ **DOB:**___/____/_____

Patient Signature: _____ **Date:** _____

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