Johnson Chiropractic &
Holistic Health Center, LLC.
Chiropractic – Acupuncture – Nutrition & Functional Medicine – Injury Rehab

Dr. Kody R. Johnson, DC, MTAA

Authorization for Release of Health Records

From Johnson Chiropractic to Requested Party

Patient Name_____ DOB: _____ Last four of SS#: _____

_____

Address City, Sate Zip Phone Number

I, _____, hereby authorize Johnson Chiropractic & Holistic Health Center, LLC to use or disclose protected health information about me as outlined below.

The following listed person and / or facility may receive disclosure of my protected health information:

_____

Name of Person & / or Facility Receiving Information Phone Number

_____

Address of Person & / or Facility Receiving Information Fax Number

Please release the following information: **Dates of treatment to be released**: From: _____ To _____

□ All patient records: Intake, Notes, Labs, Reports, etc. □ SOAP / Progress Notes □ Radiology Reports - o include CD copy

□ Laboratory Reports □ Operative Report and / or Diagnostic Tests □ MRI's □ Account Summary's and / or Billing Statements

□ Other: _____

_____I understand that the person and / or facility listed above may obtain or release my protected health information.

_____I understand that the information used or disclosed may be subject to re-disclosure by the person and / or facility receiving it, and would then no longer be protected by federal privacy regulations.

_____I may revoke this authorization by notifying Johnson Chiropractic & Holistic Health Center, LLC in writing of my desire to withdraw this signed authorization for release of health records. I understand that any action taken in accordance to this authorization cannot be undone, and my withdrawal of this authorization for release of health records will only affect actions taken after authorization has been terminated.

_____I may update authorized person and / or facility at any time, in person at Johnson Chiropractic & Holistic Health Center, LLC located at 908 Rain Forest Parkway, Suite B. – Columbia, MO 65202.

_____This authorization will expire 6 months from the date of signature, OR on the following date: _____.

Consent to Privacy Practices:

- Your health information is considered to be protected and confidential. Under federal law (HIPAA), Our Clinic must keep your protected health information (PHI) confidential and can only use it within certain guidelines, which may be subject to your prior approval. Our Clinic will use your PHI in order to formulate an appropriate diagnosis and treatment plan, make any necessary referrals; collect payment from your insurance company, attorney, yourself, or any other necessary collections agency, or individual. Of course, you may limit how we use and to whom we disclose your PHI to. You must put any exceptions in writing and give it to our front desk staff. By signing this form, you are agreeing to our privacy practices. You are also giving our office the ability to contact you by any means necessary, including but not limited to: mail, email, telephone, fax, etc. If you would like a copy of Our Clinic's "privacy practices policy", please ask any of our staff and they will provide you with one.

By signing below, I am acknowledging that I agree with the aforementioned privacy practices and that I am consenting to the release of my health records to the above listed person and / or facility.

_____ | _____ | _____

Patient Name Printed Patient Signature Date of Signature

_____ | _____ | _____

Guardian/Personal Representative Signature Date of Signature Description of Authority to Act for Patient