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 Requested Party to Johnson Chiropractic

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

_____
Address City, Sate Zip Phone Number

I, _____, hereby authorize the requested person and / or facility listed below to release my protected health information to Dr. Kody R. Johnson as outlined below.

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

_____
Name of Person & / or Facility Releasing Information Phone Number

_____
Address of Person & / or Facility Releasing Information Fax Number

Records requested are to be sent to: 908 Rain Forest Parkway, Suite B – Columbia, MO 65202

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

□ All patient records □ SOAP / Progress Notes □ MRI's □ Radiology Reports - o include CD copy

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

□ Other: _____

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

_____I understand that the information released 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 from 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