FALLING WATERS

INJURY & HEALTH MANAGEMENT

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____ Date of Birth _____

1. I authorize Falling Waters, LLC to disclose my health information to:

   Individual or entity authorized to receive my health information_____

   Address _____ City_____ State ____ Zip_____

   Phone _____ Fax _____

2. Purpose for which disclosure is to be made: _____
3. Case type of disclosure: ❒ General Insurance ❒ Personal Injury ❒ Worker Compensation
4. Disclosure from which health professional: ❒ Chiropractic Sports Physician ❒ Physical Therapist
5. Date or time period of disclosure: _____

   Information to be disclosed:

   ❒ Intake
   ❒ Initial Consult Notes
   ❒ Chart Notes
   ❒ Laboratory Report
   ❒ Radiology Report
   ❒ All records indicated in time frame. Start Date:_____End Date: _____
   ❒ Specialist/consult report from: _____
   ❒ Other: _____

Restriction Requested: _____

By checking and initializing the space(s) below, I am specifically authorizing release of the following:

❒ Medical Records from alcohol and/or drug abuse treatment center(s) _____
❒ HIV test date(s) – NO RESULTS _____
❒ HIV test results _____
❒ Genetic Testing Results _____

*Note HIV are one time releases **Psychiatric (mental health) records require a separate release form per ORS 192.525

I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Falling Waters, LLC, its employees, management service and physicians from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 day from the date signed below. I understand that I may revoke this authorization by notifying in writing, the Medical Records Dept, knowing that previously disclosed information would not be subject to my revoke request.

I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Signature _____ Date _____ _____

❒Patient ❒Guardian Falling Waters Witness Signature

FD:

❒ Ensure Front Page complete
❒ Sign "Witness Signature" on bottom of first page
❒ Inform patient we legally have 30 days to complete however we strive to have records done ASAP.
❒ Place form in Billing Bin

Billing:
❒ Complete and process the appropriate Records Request Checklist

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