REQUEST FOR MEDICAL RECORDS

PATIENT NAME: _____ DATE: _____

Patient Identification:	Social Security No/ID: Medical Record No:	Date of Birth:

I REQUEST THAT MY MEDICAL RECORDS/IMAGING STUDIES AT THE FOLLOWING FACILITY: (Name/Address of Doctor/Facility where the patient's medical records are located):

Name:	
Address:	

BE SENT TO:

Doctor's Name:	**Douglas F. Cancel. D.C**
Address:	PO Box 3915, Walnut Creek, CA 94598
Telephone:	925-945-1155 / 925-945-1440 FAX (secure)

WHAT MEDICAL RECORDS ARE BEING AUTHORIZED TO BE DISCLOSED AND MAILED:

☐ All Medical Records pertaining to:_____

☐ X-Ray/MRI/CT studies pertaining to the neck, back, and/or spine with the attending Radiologist Report(s).

☐ EMG, SSEP, Nerve Conduction, Laboratory tests, Diagnostic Test Reports

☐ Other _____

SPECIFIC DATES AUTHORIZED FOR RECORDS RELEASE

Medical records from (insert date) _____ to (insert date)_____

PURPOSE OF RELEASE OF INFORMATION

☐ Review for the purpose of evaluation, treatment, or providing an opinion on my injury or medical condition.

☐ Other: _____

I hereby request and voluntarily authorize disclosure of the above protected health information in my medical records kept at your office or facility to be photocopied, released and mailed to **Douglas F. Cancel, DC**, **P.O. Box 3915, Walnut Creek, CA 94598**, for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on-site, and 60 days if stored off-site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment.

EXPIRES: This authorization is good for 12 months from the date signed for the disclosure of the information described above.
*This authorization does not apply to any records/notes regarding HIV/AIDS, communicable disease, alcohol or drug treatment, mental health information, behavioral health care, domestic violence, genetic testing, and psychiatric or psychotherapy notes.

Patient Name (Print Clearly): _____

Individual Authorizing Disclosure: _____/_____

Signature **Date**

If not signed by the patient, specify basis for your authority to sign: ☐ Parent of minor, ☐ Guardian

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical information under HIPAA: 45 CFR Parts 160 and 164, 42 CFR part 2, 38 CFR, 34 CFR parts 99 and 300, and State law.