



AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Date of Birth: _____

Other names under which records might be filed: _____

Person/Organization requesting information from:

Bilan Chiropractic
400 W Northern Lights Ste. 6
Anchorage, AK 99508
(907)569-1123 Fax: (907) 569-1180

Person/Organization receiving information: _____

Information to be released: _____

Dates of records: _____

Dates the records will be returned: _____

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

I hereby authorize the use or disclosure of my health care and/or other information as described by me above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization at any time by on actions taken on this authorization before my revocation was received. I understand that if the organization authorized to receive this information is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

Signature of Patient or Personal Representative

Date

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL