AUTHORIZATION TO RELEASE INFORMATION

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows Rochester Spine & Sports Chiropractic, PLLC to receive or release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to us. Revoking this authorization will not affect any action taken prior to receipt of your written request.

SECTION A. Member Information: (individual whose information will be released)

Name: (First, Middle, Last)	**Date of Birth:** (Month/Day/Year)
Address: (including zip code)	**Telephone Number:** (including area code)

SECTION B. Health Organization: (person or organization that will release your information)

I authorize _____ to release my protected health information as described below.

SECTION C. Recipient: (person or organization that will receive your information)

Person's Name or Organization: Dr. Matt Buffan Rochester Spine + Sports Chiropractic, PLLC	**Telephone Number:** 585-678-1362
Address: 121 Sully's Trail Ste #7; Pittsford, NY 14534 & 3543 Winton Place; Rochester, NY 14623	**Fax Number:** 585-419-7048

SECTION D. Description of the information to be released:

Specific information as described on the line below:

_____

NOTE: State law requires that you give specific permission to release the information below. Indicate your permission for Rochester Spine & Sports Chiropractic, PLLC to release any of the following information by initialing all that apply.

Genetic Information _____ (initials) **HIV/AIDS** _____ (initials)
Substance/Alcohol Abuse _____ (initials) **Mental/Behavioral Health** _____ (initials)

Purpose of Release: _____

SECTION E. Expiration: (when this authorization will end)

This authorization will expire upon the following date, event or condition:

_____

SECTION F. Approval: (You OR a Personal Representative must sign and date this form for it to be complete)

I understand that this authorization to release information is voluntary and is not a condition of becoming a patient of Rochester Spine & Sports Chiropractic, PLLC. I also understand that if the person or organization that I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Patient Signature

By signing below, I authorize release of my protected information as described above:

_____
(Print Name)

_____
(Signature)

_____
(Date)

Guardian or Personal Representative

The person who has the legal authority to act on behalf of an individual.

_____
(Print Name)

_____
(Signature)

_____
(Date)