DEMETREE CHIROPRACTIC GROUP

3505 S. Orlando Drive
Sanford, FL 32773
Tel. (407) 324-8222 Fax (407)324-8998

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: ____

Date of Birth: ____________________ **Account No.:**______________

- ☐ I hereby **do not** authorize the release of my protected health information at this time.
- ☐ I hereby **authorize** medical providers and personnel of Demetree Chiropractic Group to discuss my protected health information with:

_________________________________ _______________________
(Name) (Relationship)

_________________________________ _______________________
(Name) (Relationship)

_________________________________ _______________________
(Name) (Relationship)

I understand that certain information cannot be released without specific authorization as required by state federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ Information regarding the patient's diagnosis and treatment

_____ Information regarding scheduled appointments

This authorization shall be in force and in effect from ___________ until ____________ at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

___________________________________ ___________________________________
Name of Patient/Personal Representative **Signature of Patient/Personal Representative**

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Date

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