Symmetry Health
4432 Ingraham Street
San Diego, Ca 92109
Phone: (858) 270-2225 Fax: (858) 270-6898
www.SymmetryHealthChiro.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____
Last First MI

Patient Address: _____
Street address City State Zip code

I hereby authorize:

Medical Professional or Facility:_____

Address:_____

Phone: _____ Fax: _____

To Disclose my Protected Health Information **to**:

☐ **Michael Wilson, DC**
4432 Ingraham St
San Diego, CA 92109
Phone: (858) 270 – 2225
Fax: (858) 270 – 6898

☐ **Danielle Schwaderer, ND**
4432 Ingraham St
San Diego, CA 92109
Phone: (858) 270 – 2225
Fax: (858) 270 – 6898

By **initialing** the spaces below, I specifically authorize the release of the following records:

_____ Complete medical record _____ Laboratory records _____ X-ray(s) (don't send films over 2 years old)
_____ Treatment Plans _____ SOAP note _____ Other:_____

For the specific purpose of: _____

_____

Please send patient's medical record via: ☐ **Electronic Medical Record** ☐ **Fax** ☐ **Mail**

I understand I have the right to: Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization; Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization; Inspect a copy of Protected Health Information being used or disclosed under federal law; Refuse to sign this authorization; Receive a copy of this authorization; Restrict what is disclosed with this authorization. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information. Unless revoked earlier, this consent will expire 180 days from the date of signing. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

_____ _____ _____
Name of Requesting Doctor Signature of Requesting Doctor Date