AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM SERENA SARA CHIROPRACTIC CENTER,PLLC

DELIVERY METHOD **(Check one)**

EMAIL _____ **OR** MAIL(Patient to pay postage)_____

EMAIL ADDRESS_____ Mailing Address:_____

I hereby authorize the use and/or disclosure of the below named individual's health information as described below:

I hereby authorize Serena Sara Chiropractic Center,PLLC to make the disclosure of health information in the manner described herein of the records of the below listed patient:

Patient Name: _____

Phone Number: _____

Date of Birth: _____

Address: _____

What health information are you requesting to be released? Check the applicable lines:

Progress notes_____

Exams_____

Diagnostic testing records_____

Sign in sheets_____

Insurance explanation of benefits_____

Ledger of charges and payments_____

Dates of records requested_____

Purpose for which this request is being made for: **(circle the appropriate answer):**

Continuation of care/Other- ie insurance, self, legal purposes

I understand that I have the right to revoke this authorization at any time, and that if I revoke this authorization, I must send a written request to Serena Sara Chiropractic Center,PLLC,8234 SW 81 Terrace, Miami,FL 33143. I understand that the revocation will not apply to information that has already been released in reliance on this authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that the information released may include mental health records,communicable diseases including, but not limited to HIV and AIDS, alcohol/drug abuse treatment records,and genetic information. **PATIENT TO INITIAL:**_____

Authorization will expire one year from the date on which it was signed unless another date or event is specified. I understand that I can get a copy of this form after I sign it. **PATIENT TO INITIAL:**_____

I understand that this authorization is voluntary. I understand that once the health information described herein is disclosed, it may be redisclosed by the recipient and may no longer be protected by federal privacy laws. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

SIGNATURE OF PATIENT_____ **PRINT NAME OF PATIENT**_____

DATE_____

Please email completed form to dr.sarastaff@hotmail.com, or mail to 8234 SW 81 Terrace,Miami,FL 33143/ Any Questions call 305-431-2713.