KUKURIN CHIROPRACTIC NETWORK

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**

Requestor Name: Dr. George W. Kukurin

Requestor Company Name (if applicable):
Kukurin Chiropractic Network

Requestor Address:
12409 W Indian School Road, Suite C304

City:	**State:**	**Zip:**
Avondale	AZ	85323

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:** Only after a written request to terminate authorization to release information **.**

Purpose of disclosure: Continuity and continuation of direct patient care.

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. [X] No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
[X] Entire Record	all	☐ Pathology Reports		[X]Other: Diagnostic study	all
☐ Discharge Summary		☐ Emergency Room Record		reports.	
[X] History and Physical	all	[X] Radiology Reports	all		
☐ Operative Reports		☐ Nursing Notes		[X] Billing/insurance	all
[X]Laboratory Reports	all	[X] Physician Progress Notes	all	information	
☐ Consultation Reports		☐ Physician Orders			
☐ Medication Reports		☐ Other:			

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing? NO
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes [X] No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative:	**Date:**
Print Name of Patient/Patient Representative:	**Relationship to Patient:**

FAX RECORDS REQUEST TO

_____

_____

_____

SEND MEDICAL RECORDS TO

GEORGE W KUKURIN DC DACAN

12409 W INDIAN SCHOOL RD #C304

AVONDALE AZ 85392 FAX 623-9728411