AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL MEDICAL INFORMATION FOR CHIROPRACTIC SERVICES

In order to provide you with the best chiropractic care while maintaining E.A. Hawse Health Center's standards of quality of care, we ask that you provide us with the following documentation from your primary care provider.

_____ _____
Last Name, First Name, MI Date of Birth

_____ _____
Address Last 4 numbers of SSN

_____
Home Phone Number Work Phone Number

AUTHORIZATION

I HEREBY AUTHORIZE:

Name/Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

TO RELEASE MEDICAL INFORMATION TO:

E.A. Hawse Health Center, Inc

Jacob Metheny, DC

[ ] E.A. Hawse Health Center
PO Box 97
Baker, WV 26801
PH: 304-897-5915
FAX: 304-897-5917

[ ] Grove Street Health Center
111 South Grove Street, Suite #1
Petersburg, WV 26847
PH: 304-257-2451
FAX: 304-257-1263

DATES OF SERVICE: FROM _____ TO _____

Please include the following information:

- Medication List
- Problem Lists
- Lab Results (if diabetic)
- Pain Relief Injections
- Pap Report (if female—AGE 23-64)
- Colonoscopy Report (AGE 50-75)
- Xray/Imaging Results (if pertains to chiropractic treatment)
- Prior Surgical History (if pertains to chiropractic treatment)

Attestations:

____ I understand that this consent is voluntary and that I may revoke in writing, signed and dated for E.A. Hawse Health Center. This request will expire in 365 days from the date of signature.

____ I may refuse to sign this authorization. If I refuse, the medical records will not be accepted or released.

____ Releases or requests meet the requirements of HIPAA.

____ This release/request has been [ ] accepted [ ] rejected by the patient's representative of record.

_____ _____ _____
Patient's Signature Guardian Signature Date

Released by: _____ **Date: _____**