Advanced Chiropractic
Health Center
Working for your wellness, naturally

Charles W. Chapple, D.C., F.I.C.P.A.
Acupuncture, Applied Kineseology
and Chiropractic Pediatric Certified

I,_____, hereby
(patient name)
authorize _____
(name of hospital/facility)
to provide to_____
(name & address of individual/facility)
the medical data and information designated below, concerning my injury or illness.
For the purpose of _____
For the dates of service _____

___Pertinent records
___Lab reports
___Diagnostic imaging reports
___Emergency room record
___History & physical
___Discharge summary
___Operative report
___Cancer center reports
___Physical therapy notes
___Other(specify)_____

I consent to specifically releasing the following records which are protected by the Federal Confidentiality Regulations: (check those that apply)

___Psychiatric/Mental Health Treatment; psychotherapy notes
___HIV/AIDS; other sexually transmitted diseases
___Drug and alcohol information

I understand that the information used or disclosed may be subject to redisclosure by the recipient. This authorization is valid for 90 days unless revoked in writing. I understand that I have a right to revoke my authorization at any time and that it must be in writing to be valid, except as documented in the Washington State Healthcare Information Act (section 203) and unless disclosure is required to obtain payment for care that has already been rendered. This revocation will become a permanent part of my record. I consent to transmitting via facsimile this information in an emergency situation.

Signature_____
(Patient/guardian/legal representative)
Date/Time:_____

Witness:_____

Print Patient Name_____Birthdate_____
Telephone number_____

Revised Date: March 2003